Washington RBRVS Payment Policies

The policies outlined in this section apply only to providers and services paid with the Washington RBRVS payment system. Many of the policies contain information previously published in Provider Bulletins.

In addition to the policies outlined in this section, all providers must follow the administrative rules, medical coverage decisions and payment policies contained within the *Medical Aid Rules and Fee Schedules, Provider Bulletins,* and *Provider Updates*. If there are any services, procedures, or text contained in the CPT and HCPCS coding books that are in conflict with the *Medical Aid Rules and Fee Schedules*, the department's rules and policies apply (WAC 296-20-010). All policies in this document apply to claimants receiving benefits from the State Fund, the Crime Victims Compensation Program and Self-Insurers unless otherwise noted.

Questions may be directed to the Provider Hotline at 1-800-848-0811.

CONTENTS

WASHINGTON RBRVS PAYMENT SYSTEM AND POLICIES

The implementation of the department's Washington Resource Based Relative Value Scale (RBRVS) payment system began September 1, 1993. Conversion to this payment method occurred over a transition period and was completed May 1, 1995.

WASHINGTON RBRVS PAYMENT POLICIES

Payment policies listed in the fee schedule are established by the department and the Washington Reimbursement Steering Committee (RSC). The RSC is a standing committee with representatives from the Department of Labor and Industries, the Health Care Authority and the Department of Social and Health Services. The RSC receives payment policy advice from the Washington Reimbursement Technical Advisory Group (TAG). The TAG represents most major physician specialties and provider groups in the state.

BASIS FOR CALCULATING RBRVS PAYMENT LEVELS

RBRVS fee schedule allowances are based on relative value units (RVUs), geographic adjustment factors for Washington State, and a conversion factor. The three state agencies use a common set of RVUs and geographic adjustment factors for procedures, but use different conversion factors.

The primary source for the current RVUs is the 2001 Medicare Fee Schedule (MFS) for physician payment, which was published by HCFA in the November 2, 2000 *Federal Register*. The *Federal Register* can be accessed online from the "Laws and Regulations" link on HCFA's website or can be purchased from the U.S. Government in hard copy, microfiche, or disc formats. The *Federal Register* can be ordered from the following addresses:

Superintendent of Documents PO Box 371954 Pittsburgh, PA 15250-7954	or	U.S. Government Bookstore 915 2nd Avenue Seattle, WA 98174

Under HCFA's approach, relative values are assigned to each procedure based on the resources required to perform the procedure, including the work, practice expense, and liability insurance (malpractice expense). The state agencies geographically adjust the RVUs for each of these components based on the costs for Washington State. The Washington State geographic adjustment factors for July 1, 2001 are: 98.9% of the work component RVU, 101.1% of the practice expense RVU, and 76.5% of the malpractice RVU.

The payment levels for each procedure are calculated by summing the adjusted RVU components, rounding the result to the nearest hundredth, and multiplying the rounded sum by the agency's conversion factor. Because the agencies use different conversion factors, payment levels vary among agencies.

The Department of Labor & Industries' RBRVS conversion factor is listed in WAC 296-20-135. The department's payment levels are published as dollar values in the "CPT & HCPCS Fee Schedule" section.

SITE OF SERVICE PAYMENT DIFFERENTIAL

The department implemented a site of service payment differential on July 1, 2000. This differential is based on the HCFA's payment policy and establishes distinct maximum fees for services performed in facility and non-facility settings. The department will pay professional services at the RBRVS rates for facility and non-facility settings based on where the service was performed. Therefore, it is important to **include a valid two digit place of service code on your bill**.

The department's maximum fees for facility and non-facility settings are published in the "CPT & HCPCS Fee Schedule" section.

Services Paid at the RBRVS Rate for Facility Settings

When services are performed in a facility setting, the department makes two payments, one to the professional provider and another to the facility. The payment to the facility includes resource costs such as labor, medical supplies and medical equipment. To avoid duplicate payment of resource costs, these costs are excluded from the RBRVS rates for facility settings.

Professional services will be paid at the RBRVS rate for facility settings when the department also makes a payment to a facility. Therefore, services billed with the following place of service codes will be paid at the rate for facility settings:

Place of Service Code	Place of Service Description
21	Inpatient hospital
22	Outpatient hospital
23	Emergency room- hospital
24	Ambulatory surgery center
25	Birthing Center
26	Military treatment facility
31	Skilled nursing facility
51	Inpatient psychiatric facility
61	Comprehensive inpatient rehabilitation facility
62	Comprehensive outpatient rehabilitation facility
(none)	(Place of service code not supplied)

Services Paid at the RBRVS Rate for Non-Facility Settings

When services are provided in non-facility settings, the professional provider typically bears the costs of labor, medical supplies and medical equipment. These costs are included in the RBRVS rate for non-facility settings.

Professional services will be paid at the RBRVS rate for non-facility settings when the department does not make a separate payment to a facility. Therefore, services billed with the following place of service codes will be paid at the rate for non-facility settings:

Place of Service Code	Place of Service Description
11	Office
12	Home
32	Nursing facility
33	Custodial care facility
34	Hospice
41	Ambulance (land)
42	Ambulance (air or water)
50	Federally qualified health center
52	Psychiatric facility partial hospitalization
53	Community mental health center
54	Intermediate care facility/mentally retarded
55	Residential substance abuse treatment center
56	Psychiatric residential treatment center
60	Mass immunization center
65	End stage renal disease treatment facility
71	State or local public health clinic
72	Rural health clinic
81	Inpatient laboratory
99	Other unlisted facility

Facilities will be paid at the RBRVS rate for non-facility settings when the department does not make a separate payment directly to the provider of the service.

Billing Tip

Remember to include a valid two digit place of service code on your bill. Bills without a place of service code will be processed at the RBRVS rate for facility settings, which could result in lower payment.

EVALUATION AND MANAGEMENT SERVICES (E/M)

PHYSICIAN CARE PLAN OVERSIGHT

The department allows separate payment for physician care plan oversight services (CPT codes 99375, 99378 and 99380). Payment is limited to one unit per attending physician, per patient, per 30-day period. Care plan services (CPT codes 99374, 99377 and 99379) of less than 30 minutes within a 30-day period are considered part of E/M services and are not separately payable.

Payment for care plan oversight to a physician providing postsurgical care during the postoperative period will be made only if the care plan oversight is documented as unrelated to the surgery, and modifier -24 is used. The attending physician (not staff) must perform these services. The medical record must document the medical necessity as well as the level of service.

MEDICAL CARE IN THE HOME OR NURSING HOME

The department allows attending physician charges for nursing facility services (CPT codes 99301-99313), domiciliary, rest home (e.g., boarding home), or custodial care services (CPT codes 99321-99333) and home services (CPT codes 99341-99350). The attending physician (not staff) must

perform these services. The medical record must document the medical necessity as well as the level of service.

CASE MANAGEMENT SERVICES

Case management services (CPT codes 99361-99373) are payable only when personally performed by the attending doctor, consultant, or psychologist performing an evaluation. These services are payable when discussing or coordinating care of a patient with department staff, vocational rehabilitation counselors, nurse case managers, department medical consultants or Self-Insurer representatives. Telephone calls for authorization, resolution of billing issues, or ordering prescriptions are not payable.

Documentation for case management services must include:

- the date,
- the participants and their titles,
- the length of the call or visit,
- the nature of the call or visit, and
- any medical decisions made during the call.

NEW AND ESTABLISHED PATIENT

The department uses the CPT definitions of *new* and *established* patients.

If a patient presents with a work related condition and meets the definition of a new patient in a provider's practice, then the appropriate level of a new patient E/M should be billed.

If a patient presents with a work related condition and meets the definition of an established patient in a provider's practice, then the appropriate level of established patient E/M service should be billed, **even if the provider is treating a new work related condition for the first time**.

PROLONGED EVALUATION AND MANAGEMENT

Payment of prolonged E/M (CPT codes 99354-99357) is allowed with a maximum of three hours per day per patient. These services are payable only when another E/M code is billed on the same day using the following HCFA payment criteria:

CPT Code	Other CPT Code(s) Required on Same Day
99354	99201-99205, 99212-99215, 99241-99245 or 99321-99350
99355	99354 *and* one of the E/M codes required for 99354
99356	99221-99223, 99231-99233, 99251-99255, 99261-99263, 99301-99303, or 99311-99313
99357	99356 *and* one of the E/M codes required for 99356

The time counted toward payment for prolonged E/M services includes only direct face-to-face contact between the physician and the patient (whether the service was continuous or not). Prolonged physician services without direct contact (CPT codes 99358 and 99359) are bundled and are not payable in addition to other E/M codes.

PHYSICIAN STANDBY SERVICES

The department pays for physician standby services (CPT code 99360) when all the following criteria are met:

- The standby service is requested by another physician,
- the standby service involves prolonged physician attendance without direct (face-to-face) patient contact,
- the standby physician is not concurrently providing care or service to other patients during this period,
- the standby service does not result in the standby physician's performance of a procedure subject to a "surgical package" by the standby physician, and
- standby services of 30 minutes or more are provided.

Subsequent periods of standby beyond the first 30 minutes may be reported and are payable only when a *full* 30 minutes of standby was provided for each unit of service reported. Round all fractions of a 30-minute time unit downward.

Justification for the physician standby service must be documented and retained in the provider's office and submitted to the department or Self-Insurer for review upon request.

TELECONSULTATIONS

The department has adopted a modified version of HCFA's policy on teleconsultations. Teleconsultations require an interactive telecommunication system, consisting of special audio and video equipment that permits real-time consultation between the patient, consultant and referring provider. **Telephones, faxes and electronic mail systems do not meet the definition of an interactive telecommunication system.**

Coverage of Teleconsultations

Teleconsultations are covered in the same manner as face-to-face consultations (refer to WACs 296-20-045 and -051), *but in addition*, **all** of the following conditions must be met:

- The **consultant** must be a doctor as described in WAC 296-20-01002, which includes a MD, DO, ND, DPM, OD, Dentist, or DC. A consulting DC must be an approved consultant with the department.
- The **referring provider** must be one of the following: MD, DO, ND, DPM, OD, Dentist, DC, ARNP, PA, or PhD Clinical Psychologist.
- The patient must be present at the time of the consultation.
- The examination of the patient must be under the control of the consultant.
- The referring provider must be physically present with the patient during the consultation.
- The consultant must submit a written report documenting this service to the referring provider, and must send a copy to the insurer.
- A referring provider who is not the attending must consult with the attending provider before making the referral.

Payment of Teleconsultations

Teleconsultations are paid in a different manner than face-to-face consultations. Also, the department and Self-Insurers pay for teleconsultations in a different manner than HCFA. Insurers may directly pay both consultants and referring providers for their services. Insurers will pay according to the following criteria:

- Providers (consulting and/or referring) must append a "GT" modifier to one of the appropriate codes listed in the table below.
- The amount allowable for the appropriate code is either 75% of the fee schedule amount, or the billed amount, whichever is less.
- No separate payment will be made for the review and interpretation of the patient's medical records and/or the required report that must be submitted to the referring provider and to the department.
- No payment is allowed for telephone line charges and facility fees incurred during the teleconsultation.

The Consultant May Bill Codes:	The Referring Provider May Bill Codes:
CPT 99241-99245	CPT 99211-99215
CPT 99251-99255	CPT 99218-99239
CPT 99261-99263	CPT 99301-99313
CPT 99271-99275	CPT 99331-99333
CPT 99241-99243 (for DCs)	CPT 99347-99357
Local 2130A-2134A (for NDs)	CPT 99211-99214 (for DCs)
	CPT 90801 (for PhD Clinical Psychologists)
	Local 2133A-2134A (for NDs)

END STAGE RENAL DISEASE (ESRD)

The department follows HCFA's policy regarding the use of E/M services along with dialysis services. E/M services (CPT codes 99231-99233 and 99261-99263) are not payable on the same service date as hospital *inpatient* dialysis (CPT codes 90935, 90937, 90945 and 90947). These E/M services are *bundled* in the dialysis service.

Separate billing and payment for an initial hospital visit (CPT codes 99221-99223), an initial inpatient consultation (CPT codes 99251-99255), and a hospital discharge service (CPT code 99238 or 99239), will be allowed when billed on the same date as an inpatient dialysis service.

APHERESIS

The department follows HCFA's policy regarding apheresis services. Separate payment for established patient office or other outpatient visits (CPT codes 99211-99215), subsequent hospital care (CPT codes 99231-99233), and follow-up inpatient consultations (CPT codes 99261-99263), will not be allowed on the same date that therapeutic apheresis (CPT code 36520) is provided.

Physicians furnishing therapeutic apheresis services may bill for the appropriate E/M visit or consultation code indicating the level of services provided rather than billing for the therapeutic apheresis services. This will permit physicians to be paid for the level of service furnished.

The time spent in apheresis management may not be counted in determining the duration of time spent on critical care services (CPT codes 99291 and 99292).

The code for therapeutic apheresis includes payment for all medical management services provided to the patient on the same date of service. Payment will be made for only one unit of CPT code 36520 provided by the same physician, on the same date, for the same patient.

SURGERY SERVICES

GLOBAL SURGERY POLICY

Services and Supplies Included in the Global Surgery Policy

The following services and supplies are included in the global surgery follow-up day period and are considered *bundled* into the surgical fee:

- The operation itself.
- Preoperative visits, in or out of the hospital, beginning on the day before the surgery.
- Services by the primary surgeon, in or out of the hospital, during the postoperative period listed in the "CPT & HCPCS Fee Schedule" section.
- Dressing changes; local incisional care and removal of operative packs; removal of cutaneous sutures, staples, lines, wires, tubes, drains and splints; insertion, irrigation and removal of urinary catheters, cast room charges, routine peripheral IV lines, nasogastric and rectal tubes; and change and removal of tracheostomy tubes. *Casting materials are not part of the global surgery policy and are paid separately.*
- Additional medical or surgical services required because of complications that do not require additional operating room procedures.

How to Apply the Follow-up Day Period

1. The follow-up day period applies to **any provider** who participated in the surgical procedure. These providers include:
    - Surgeon or physician who performs any component of the surgery (e.g. the pre, intra, and/or postoperative care of the patient; identified by modifiers -56, -54 and -55)
    - Assistant surgeon (identified by modifiers -80, -81 and -82)
    - Two surgeons (identified by modifier -62)
    - Team surgeons (identified by modifier -66)
    - Anesthesiologists and CRNAs
2. The follow-up day period always applies to the following CPT codes, *unless* modifier -24, -25, -57 or -79 is appropriately used:

E/M Codes		Ophthalmological Codes
99211-99215	99301-99303	92012-92014
99218-99220	99311-99316	
99231-99239	99331-99333	
99261-99263	99347-99350	
99291-99292		

3. Professional inpatient services (CPT codes 99221-99223) are only payable during the follow-up day period if they are performed on an emergency basis (i.e., they are not payable for scheduled hospital admissions).
4. Codes that are considered *bundled* are **not payable** during the global surgery follow-up period.

PRE, INTRA, OR POSTOPERATIVE SERVICES

The department or Self-Insurer will allow separate payment when the preoperative, intraoperative or postoperative components of the surgery are performed by different physicians. The appropriate modifiers (-54, -55 or -56) must be used. The percent of the maximum allowable fee for each component is listed in the "CPT & HCPCS Fee Schedule" section.

If different physicians perform different components of the surgery (pre, intra, or postoperative care), the global surgery policy applies to each physician. For example, if the surgeon performing the operation transfers the patient to another physician for the postoperative care, the same global surgery policy, including the restrictions in the follow-up day period, applies to all physicians.

STARRED SURGICAL PROCEDURES

In the *Surgery* section of CPT, many minor surgeries are designated by a star (*) following the procedure code.

For these starred procedures, the department follows HCFA's policy to not allow payment for an E/M office visit during the surgical global period unless:

- a documented, unrelated service is furnished during the postoperative period and modifier -24 is used, or
- the practitioner who performs the procedure is seeing the patient for the first time, in which case, an initial new patient E/M service can be billed. This is considered a significant, separately identifiable service and modifier -25 must be used. Appropriate documentation must be made in the chart describing the E/M service.

CPT code 99025, initial surgical evaluation, is considered bundled and is not separately payable. Modifier -57, decision for surgery, is not payable with minor surgeries (e.g. starred procedures). When the decision to perform the minor procedure is made immediately before the service, it is considered a routine preoperative service and a visit or consultation is not paid in addition to the procedure.

Modifier -57 is payable with an E/M service only when the visit results in the initial decision to perform *major* surgery.

STANDARD MULTIPLE SURGERY POLICY

When multiple surgeries are performed on the same patient at the same operative session or on the same day, the total payment equals the sum of:

100% of the global fee for the procedure or procedure group with the highest value according to the fee schedule

50% of the global fee for the ***second through the fifth*** procedures with the next highest values, according to the fee schedule.

Procedures in excess of five require submission of documentation and individual review to determine payment amount.

When different types of surgical procedures are performed on the same patient on the same day for accepted conditions, the payment policies should always be applied in the following sequence:

1. Multiple endoscopy policy for endoscopy procedures
2. Other modifier policies, and finally
3. Standard multiple surgery policy

BILATERAL PROCEDURES POLICY

Bilateral surgeries should be billed as two line items. Modifier -50 should be applied to the second line item. When billing for bilateral surgeries, the two line items should be treated as one procedure. The second line item is paid at 50% of the fee schedule maximum, or billed charge, whichever is less.

Be sure to check in the "CPT & HCPCS Fee Schedule" section to see if modifier -50 is valid with the procedure performed.

Example: **Bilateral Procedure**

Line item on bill	CPT code/modifier	Maximum payment (non-facility setting)	Bilateral policy applied	Allowed amount
1	64721	$520.30		$520.30 (1)
2	64721-50	$520.30	$260.15 (2)	$260.15
Total allowed amount (non-facility setting)				**$780.45** (3)

Notes:
1. Highest valued procedure is paid at 100%.
2. When applying the bilateral payment policy, the two line items will be treated as one procedure. The second line item billed with a modifier -50 is always paid at 50% of the value paid for the first line item.
3. Represents total allowable amount.

ENDOSCOPY PROCEDURE POLICY

For the purpose of these payment policies, the term, "endoscopy" will be used to refer to any invasive procedure performed with the use of a fiberoptic scope or other similar instrument.

Multiple endoscopies are grouped by "families" each containing a "base" endoscopy procedure. A base procedure is generally defined as the *diagnostic* procedure, as opposed to a *surgical* procedure. Endoscopy families are defined as procedures that are clinically related or grouped. The family groupings with identified base procedures are located in the "CPT & HCPCS Fee Schedule" section and in **Appendix A** located at the end of this section.

Payment is not allowed for an E/M office visit (CPT codes 99201-99215) on the same day as the diagnostic or surgical endoscopic procedure unless a documented, separately identifiable service is provided and modifier -25 is used.

Multiple endoscopies that are related to the primary base procedure (that is in the same family), are paid as follows:

1. 100% payment for the endoscopy with the highest relative value unit or dollar value listed in the fee schedule.
2. For the next highest valued endoscopy, payment will be based on the difference between this endoscopy and the base diagnostic endoscopy.
3. No additional payment is made for a base procedure when a family member is billed.

Once payment for all endoscopy procedures is calculated, each family is defined as an "endoscopic group." If more than one endoscopic group or other non-endoscopy procedure is billed for the same patient on the same day, by the same physician, then the standard multiple surgery policy will be applied to all procedures.

When payment for codes within a "family" are less than the base code, no add-on will be provided nor will there be a reduction in payment. Consider the portion of payment for this family member equal to $0.00.

Multiple endoscopies that are *not* related (e.g., each is a separate and unrelated procedure) are priced as follows:

1. 100% for each unrelated procedure, then
2. Apply the standard multiple surgery policy

Example #1: **Two endoscopy procedures in the same family.**

Line item on bill	CPT code	Maximum payment (non-facility setting)	Payment calculated using the endoscopy policy	Allowed amount
Base (1)	*29870*	*$546.59*	*$000.00 (2)*	
1	29874	$763.34	$216.75 (3)	$216.75 (5)
2	29880	$904.21	$904.21 (4)	$904.21 (5)
Total allowed amount (non-facility setting)				**$1,120.96** (6)

Notes:
1. Base code listed is for reference only (not included on the bill form).
2. Payment is not allowed for a base code when a family member is billed.
3. The second highest valued procedure is paid by subtracting base code value from the non-base code value (when procedures are within the same family).
4. The highest valued procedure within the same family is paid at 100%.
5. Amount allowed under the endoscopy policy.
6. Represents total allowed amount after applying all applicable global surgery policies. Standard multiple surgery policy does not apply because only one family of endoscopic procedures was billed.

Example #2: **Endoscopy with family member fee lower than the base code.**

Line item on bill	CPT code	Maximum payment (non-facility setting)	Payment calculated using the endoscopy policy	Allowed amount
Base (1)	*43235*	*$344.22*		
1	43241	$217.25	$0.00 (2)	
2	43251	$304.54	$304.54 (3)	$304.54 (4)
Total allowed amount (non-facility setting)				**$304.54 (5)**

Notes:
1. Base code is listed for reference only (not included on bill form).
2. Non-base endoscopy with fee less than the base code. When payment for codes within a family are less than the base code, no add-on will be provided nor should there be a reduction in payment. Consider the portion of payment for the lesser family member equal to $0.00.
3. The highest valued non-base procedure within the same family is paid at 100%.
4. Allowed amount under the endoscopy policy.
5. Represents total allowed amount. Standard multiple surgery policy does not apply because only one family of endoscopic procedures was billed.

Example #3: **Two surgical procedures billed with two endoscopies in the same family.**

Line item on bill	CPT code	Maximum payment (non-facility setting)	Payment rate calculated using the following payment policies: Endoscopy	Payment rate calculated using the following payment policies: Standard multiple surgery
1	11402	$190.46		$95.23 (4)
2	11406	$290.16		$145.08 (4)
Base (1)	*29830*	*$599.17*		
3	29835	$676.54	$77.37 (2)	$77.37 (5)
4	29838	$788.14	$788.14 (3)	$788.14 (5)
Total allowed amount (non-facility setting)				**$1,105.82 (6)**

Notes:
1. Base endoscopy code is listed for reference only (not included in bill form).
2. The second highest valued arthroscopy procedure is paid by subtracting base code value from the non-base code value (within the same family).
3. The highest valued arthroscopy procedure within the same family is paid at 100%.
4. Standard multiple surgery policy is applied, with the second and third highest valued surgical procedures being paid at 50% each.
5. Standard multiple surgery policy is applied, with the highest valued surgical procedure or procedure group being paid at 100%.
6. Final allowable amount after applying entire applicable global surgery policies.

MICROSURGERY

CPT code 69990 is an "add-on" surgical code which indicates that an operative microscope has been used. As an "add-on" code, it is not subject to multiple surgery rules. However, CPT code 69990 **is not** payable when:

- using magnifying loupes or other corrected vision devices, or
- use of the operative microscope is an inclusive component of the procedure, (i.e. the procedure description specifies that microsurgical techniques are used), or
- another code describes the same procedure being done with an operative microscope. For example, CPT 69990 may not be billed with CPT code 31535, operative laryngoscopy, because CPT code 31536 describes the same procedure using an operating microscope. The table below contains a complete list of all such codes:

CPT Codes not Allowed with CPT Code 69990

15756-15758	26556	31536	43116
15842	31520	31540	43496
19364	31525	31541	49906
19368	31526	31560	61548
20955-20962	31530	31561	63075-63078
20969-20973	31531	31570	64727
26551-26554	31535	31571	65091-68850

REGISTERED NURSES AS SURGICAL ASSISTANTS

Licensed registered nurses may perform surgical assistant services if the registered nurse submits all of the following documents to the department or Self-Insurer:

- A photocopy of her or his valid and current registered nurse license, and
- A letter granting on-site hospital privileges for **each** institution where surgical assistant services will be performed.

Payment for these services is **ninety** percent (90%) of the allowed fee that would otherwise be paid to an assistant surgeon (physician).

MISCELLANEOUS

Angioscopy

Payment for angioscopies (CPT code 35400) is limited to only 1 unit based on its complete CPT description encompassing multiple vessels. The work involved with varying numbers of vessels was incorporated into the RVUs.

Closure of Enterostomy

Closure of enterostomy (CPT codes 44625 and 44626) is not payable with mobilization (take down) of splenic flexure performed in conjunction with partial colectomy (CPT code 44139). If both are billed, only CPT code 44139 will be paid**.**

RADIOLOGY SERVICES

X-RAY SERVICES

Repeat X-Rays

No payment will be made for excessive or unnecessary x-rays. Repeat or serial x-rays may be performed only upon adequate clinical justification to confirm changes in the accepted condition(s) when need is supported by documented changes in objective findings or subjective complaints.

Number of Views

There is no code or modifier that is specific for "additional views" for radiology services. Therefore, the number of views of x-rays that may be paid is determined by the CPT description for the particular service.

For example, the following CPT codes for radiologic exams of the spine are payable as outlined below:

CPT Code	Payable
72020	Once for a single view
72040	Once for 2-3 views
72050	Once for four or more views
72052	Only once no matter how many views it takes to complete the series

RT and LT Modifiers

HCPCS modifiers -RT (right side) and -LT (left side) *do not affect payment*, but may be used with CPT radiology codes (CPT codes 70010-79999) to identify duplicate procedures performed on opposite sides of the body.

Portable X-Rays

Radiology services furnished in the patient's place of residence are limited to the following tests, which must be performed under the general supervision of a physician:

- Skeletal films involving extremities, pelvis, vertebral column or skull
- Chest or abdominal films that do not involve the use of contrast media
- Diagnostic mammograms

HCPCS codes for transportation of portable x-ray equipment R0070 (one patient) or R0075 (multiple patients) may be paid in addition to the appropriate radiology code(s).

Custody

X-rays must be retained for ten years. See WAC 296-23-140 (1).

CONSULTATION SERVICES

CPT code 76140, x-ray consultation, is not covered. For radiology codes where a consultation service is performed, providers should bill the specific x-ray code along with the local modifier -1R. For example, if a consultation is made on a chest x-ray, single view, frontal, the provider should bill 71010-1R.

Separate payment will not be made for review of films taken previously or elsewhere if a face-to-face service is performed on the same date as the x-ray review. Review of records and diagnostic studies is bundled into the E/M, chiropractic care visit or other procedure(s) performed.

Payment for a radiological consultation will be made at the same rate established for the professional component (modifier -26) for each specific radiology service. A written report of the radiology consultation is required.

CONTRAST MATERIAL

Separate payment will not be made for contrast material unless a patient requires low osmolar contrast media (LOCM). LOCM may be used in intrathecal, intravenous, and intra-arterial injections for patients with one or more of the following conditions:

- A history of previous adverse reaction to contrast material, with the exception of a sensation of heat, flushing, or a single episode of nausea or vomiting,
- A history of asthma or allergy,
- Significant cardiac dysfunction including recent imminent cardiac decompensation, arrhythmias, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension,
- Generalized severe debilitation, or
- Sickle cell disease.

To bill for LOCM, use the appropriate HCPCS code, A4644, A4645 or A4646. The brand name of the LOCM and the dosage must be documented in the patient's chart. HCPCS codes and payment levels are listed in the fee schedules.

Billing Tip HCPCS codes A4644, A4645 and A4646 are paid at a flat rate based on the Average Wholesale Price (AWP) per ml. Bill one unit per ml.

NUCLEAR MEDICINE

The standard multiple surgery policies as defined earlier in this section, apply to selected radiology codes for nuclear medicine services. Therefore, the multiple procedures reduction will be applied when these codes are billed:

- with other codes that are subject to the standard multiple surgery policy and,
- for the same patient, on the same day, by the same physician or by more than one physician of the same specialty in the same group practice.

The affected CPT codes are identified in the "CPT & HCPCS Fee Schedule" section under the multiple surgery indicator (MSI) column and include:

CPT Code	Abbreviated Description
78306	Bone imaging, whole body
78320	Bone imaging(3D)
78802	Tumor imaging, whole body
78803	Tumor imaging (3D)
78806	Abscess imaging, whole body
78807	Nuclear localization/abscess

MEDICINE SERVICES

BIOFEEDBACK

Biofeedback treatment requires an attending doctor's order. The extent of biofeedback treatment is limited to those procedures allowed within the scope of practice of the licensed and approved biofeedback provider administering the service.

WAC 296-21-280 limits provision of biofeedback to those practitioners who are either certified by the Biofeedback Certification Institute of America or who meet the certification requirements. The WAC also sets forth authorized conditions, treatment limitations and reporting requirements for biofeedback services.

Anyone who is a qualified or certified biofeedback provider as defined in WAC 296-21-280, but is *not* licensed as a practitioner as defined in WAC 296-20-01002 may not receive direct payment for biofeedback services. These persons *may perform* biofeedback as a para-professional as defined in WAC 296-20-015 under the direct supervision of a qualified, licensed practitioner whose scope of practice includes biofeedback and who is BCIA certified or meets the certification qualifications. The supervising licensed practitioner must bill the biofeedback services. Psychologists and psychiatrists should refer to WAC 296-21-270 and to "Psychiatric Services" later in this section.

The following table contains the biofeedback codes payable to approved providers:

Code	Abbreviated Description	Payable to:
CPT 90875	Psychophysiological thrpy 20-30 min	Department approved biofeedback providers who are: Clinical Psychologists or Psychiatrists (MD or DO).
CPT 90876	Psychophysiological thrpy 45-50 min	Department approved biofeedback providers who are: Clinical Psychologists or Psychiatrists (MD or DO).
CPT 90901	Biofeedback, any modality	Any department approved biofeedback provider
CPT 90911	Biofeedback, peri/uro/rectal	Any department approved biofeedback provider
Local 1042M	Biofeedback initial evaluation, 1 hr	Any department approved biofeedback provider
Local 1043M	Biofeedback follow-up evaluation, 30 min	Any department approved biofeedback provider
HCPCS E0746	Electromyography, (EMG) biofeedback device	DME or pharmacy providers (for rental or purchase). Bundled for RBRVS providers for use in the office.

Note: CPT codes 90901 and 90911 are not time limited, and only one unit of service per day is payable, regardless of the length of the biofeedback session or number of modalities. The local codes (codes 1042M and 1043M) for diagnostic evaluation are payable in addition to treatment on the same day. Initial evaluation is limited to once per claim per provider.

EMG SERVICES

Payment for needle electromyography (EMG) services (CPT codes 95860-95870) is limited as follows:

CPT Code	Abbreviated Description	Limitations
95869	Muscle test, thoracic paraspinal	• May be billed alone (for thoracic spine studies only) • Limited to 1 unit per day • For this to pay with extremity codes, test must be for T3-T11 areas only; if only T1 or T2 are studied, it's not payable separately.
95870	Muscle test, non-paraspinal	• Limited to 1 unit per extremity *and* 1 unit for cervical or lumbar paraspinal muscles regardless of the number of levels tested. • Not payable with extremity codes. (5 units maximum payable)
95860	Muscle test, one limb	• Extremity muscles innervated by 3 nerves or 4 spinal levels must be evaluated with a minimum of 5 muscles studied. • Not payable with CPT code 95870
95861	Muscle test, two limbs	
95863	Muscle test, 3 limbs	
95864	Muscle test, 4 limbs	

PSYCHIATRIC SERVICES

The policies in this section apply only to workers covered by the State Fund and Self-Insured employer workers (see WAC 296-21-270). For information on psychiatric policies applicable to the Crime Victims Compensation Program, refer to the department's booklet *Mental Health Treatment Rules and Fees* and WAC 296-31.

Coding and Payment Policies

A psychiatrist can only be the attending physician on a claim when a psychiatric condition is the **only** condition being treated, and it has been accepted by the department. Psychologists can not be the attending physician and may not certify time loss or rate Permanent Partial Disability under department rules (WAC 296-20-210).

Psychiatric evaluation and treatment services provided by social workers, psychiatric nurse practitioners, and other master's level counselors are **not covered,** even when delivered under the direct supervision of a clinical psychologist or a psychiatrist. Psychological testing may be administered by staff supervised by a psychiatrist or licensed clinical psychologist. However, the interpretation of testing and preparation of reports must be performed by the psychiatrist or licensed clinical psychologist.

The following policies apply to *both* psychiatrists (MD or DO) and clinical psychologists (PhD) when billing the Washington State Fund and Self-Insured employers:

- Services **must** be performed by either a psychiatrist or a psychologist, per WAC 296-21-270.
- Each provider must obtain his/her own L&I provider account number for billing and payment purposes.
- Licensed clinical psychologists and psychiatrists are paid at the same rate when performing the same service.
- When biofeedback is the only service being performed, refer to the "Biofeedback" policy earlier in this section. When biofeedback is performed in conjunction with individual psychotherapy, use either CPT code 90875 or 90876 for psychophysiological therapy instead of CPT codes 90901 or 90911 with the individual psychotherapy codes.
- The following limits apply to testing codes:

  CPT code 96100, psychological testing/per hour, has a 4 hour maximum.

  CPT code 96117, neuropsychological testing/per hour, has a 12 hour maximum.
- A psychiatric diagnostic interview examination (CPT code 90801) requires prior authorization before it can be paid. Authorization for CPT code 90801 is limited to only one occurrence every six months, per patient, per provider.

To report individual psychotherapy, use the time frames listed in the CPT codes for each unit of service. When billing these codes, do not bill more than one unit per day. When the time frame is exceeded for a specific code, bill the code with next highest time frame.

The following services are not covered:

CPT Code	Abbreviated Description
90802, 90810-90815, 90823-90829 and 90857	Interactive psychiatric interview/exam and interactive psychotherapy
90845	Psychoanalysis
90846	Family psych tx w/o patient
90849	Multiple family group psych tx

The following services are bundled and are not separately payable:

CPT Code	Abbreviated Description
90885	Psy evaluation of records
90887	Consultation with family
90889	Preparation of report

Individual Insight Oriented Psychotherapy With or Without an E/M Component

Individual insight oriented psychotherapy services are divided into services *with* an Evaluation and Management (E/M) component, and services *without* an E/M component. Coverage of these services is different for psychiatrists and clinical psychologists.

Psychiatrists may bill individual insight oriented psychotherapy codes either *with* or *without* an E/M component (CPT codes 90804-90809, 90816-90819 and 90821-90822). Psychotherapy *with* an E/M component may be billed when services such as medical diagnostic evaluation, drug management, writing physician orders, and/or interpreting laboratory or other medical tests are conducted along with psychotherapy treatment.

Clinical psychologists may bill only the individual insight oriented psychotherapy codes *without* an E/M component (CPT codes 90804, 90806, 90808, 90816, 90818 and 90821). They may not bill psychotherapy with an E/M component because medical diagnostic evaluation, drug management, writing physician orders, and/or interpreting laboratory or other medical tests are outside the scope of clinical psychologist licensure.

Further explanation of this policy and HCFA's response to public comments about it are published in the *Federal Register* Volume 62 Number 211, issued on October 31, 1997.

Evaluation and Management

Per WAC 296-21-270 all referrals for psychiatric care require prior authorization. This includes referrals for psychiatric consultations and evaluations. When an authorized referral is made to a psychiatrist, he or she may bill either the evaluation and management consultation codes (CPT codes 99241-99275) or the psychiatric diagnostic interview examination code (CPT code 90801). When an authorized referral is made to a clinical psychologist for an evaluation, he or she may bill only the psychiatric diagnostic interview examination code (CPT code 90801). Refer to WACs 296-20-045 and 296-20-051 for further details on consultation requirements.

Pharmacological Evaluation and Management

Pharmacological evaluation (CPT code 90862) is payable only to psychiatrists. If a pharmacological evaluation is conducted on the same day as individual psychotherapy, the psychiatrist should bill the appropriate psychotherapy code with an E/M component. The psychiatrist should not bill the individual psychotherapy code and a separate E/M code in this case (CPT codes 99201-99215). No payment will be made for psychotherapy and pharmacology management services performed on the same day, by the same physician, on the same patient.

HCPCS code M0064 is not payable in conjunction with the pharmacological evaluation code (CPT code 90862), or with a CPT Evaluation and Management office visit or consultation code (CPT codes 99201-99215, 99241-99275). The description for HCPCS code M0064 is "Brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental psychoneurotic and personality disorders." It will only be payable if these described conditions are accepted by the department as industrially related.

Group Psychotherapy Services

Group psychotherapy treatment (CPT code 90853) is authorized on an individual case by case basis only. If authorized, the worker may participate in group therapy as part of his or her individual treatment plan. The department does not pay a "group rate" to providers who conduct psychotherapy exclusively for groups of injured workers.

If group psychotherapy is authorized and performed on the same day as individual insight oriented psychotherapy (with or without an E/M component), both services may be billed, as long as they meet the CPT definitions.

Use of CPT's Evaluation and Management (E/M) Codes for Case Management

Case management services (CPT codes 99361, 99362 and 99371-99373) may be billed by both psychiatrists and clinical psychologists only when providing a consultation or evaluation (refer to the "Consultations" section above). To bill for case management services, psychiatrists and clinical psychologists must meet the criteria and documentation requirements specified under "Case Management Services" in the "Washington RBRVS Payment Policies" section.

After Hours Services

After hours services are payable in addition to other services only when the provider's office is not regularly open during the time the service is provided. Only one service is payable per day. These services include:

CPT Code	Abbreviated Description
99050	Medical services after hrs
99052	Medical services at night
99054	Medical services, unusual hrs

Use of CPT's Evaluation and Management Codes for Office Visits

Psychologists may not bill the E/M codes for office visits. Psychiatrists may not bill the E/M codes for office visits on the same day psychotherapy is provided for the same patient. If it becomes medically necessary for the psychiatrist to provide an E/M service for a condition other than that for which psychotherapy has been authorized, the provider must submit documentation of the event, and request a review before payment can be made.

Narcosynthesis and Electroconvulsive Therapy

Narcosynthesis and electroconvulsive therapy require prior authorization. Authorized services are payable only to psychiatrists because they require the administration of medication.

Neuropsychological Testing

The following three codes may be used if appropriate when performing neuropsychological evaluation. Reviewing records and/or writing and submitting a report is included in these codes and may not be billed separately.

CPT Code	Abbreviated Description	Billing Restriction
90801	Psy dx interview	May be billed only once every 6 months.
96100	Psychological testing/per hour	May be billed up to a 4 hour maximum. Can be billed in addition to CPT code 96117.
96117	Neuropsychological testing/per hour	May be billed per hour up to a 12 hour maximum.

OSTEOPATHIC MANIPULATIVE TREATMENT

Only osteopathic physicians may bill osteopathic manipulative treatment (OMT) using CPT codes 98925 to 98929. CPT code 97140, manual therapy, is not covered for osteopathic physicians.

For OMT services (CPT codes 98925-98929) body regions are defined as: head region, cervical region, thoracic region, lumbar region, sacral region, pelvic region, lower extremities, upper extremities, rib cage region, abdomen and viscera region. These codes ascend in value to accommodate the additional body regions involved. Therefore, only one code is payable per treatment. For example, if three body regions were manipulated, one unit of CPT code 98926 would be payable.

OMT includes pre- and post- service work (e.g. cursory history and a palpatory examination). E/M office visit services are not to be routinely billed in conjunction with OMT. E/M office visit services (CPT codes 99201-99215), may be billed in conjunction with OMT *only when all the following conditions are met:*

- When the E/M service constitutes a significant separately identifiable service that exceeds the usual pre- and post- service work included with OMT.
- There is documentation in the patient's record which supports the level of E/M billed.
- The E/M service is billed using the -25 modifier. *E/M codes billed on the same day as OMT codes without the -25 modifier will not be paid.*
- The E/M service may be caused or prompted by the same diagnosis as the OMT service. A separate diagnosis is not required for payment of E/M in addition to OMT services on the same day.

The department or Self-Insurer may reduce payment or process recoupments when E/M services are not documented sufficiently to support the level of service billed. CPT provides a list of key components which must be present for each level of service.

Appendix F in the "Washington RBRVS Payment Policies" section lists the reporting requirements for CPT codes.

PHYSICAL MEDICINE

This section applies to Medical and Osteopathic physicians.

Coding and Payment Policies

Board Certified/Qualified Physical Medicine Providers

Medical or Osteopathic physicians who are board qualified or board certified in physical medicine and rehabilitation may be paid for CPT codes 97001 through 97799 for physical medicine services. CPT code 97010, application of hot or cold packs, is bundled. CPT code 64550, application neurostimulator (TENS), is payable only once per claim.

Supervised modalities and those therapeutic procedures which do not list a specific time increment in their description are limited to one unit per day.

Non-Board Certified/Qualified Physical Medicine Providers

Special payment policies apply for attending doctors who are not board qualified or certified in physical medicine and rehabilitation:

- Attending doctors who are not board qualified or board certified in physical medicine and rehabilitation *will not be paid* for CPT codes 97001-97799. They may *perform* physical medicine modalities and procedures described in CPT codes 97001-97750 if their scope of practice and training permit it, but must *bill* local code 1044M for these services.

- Local code 1044M is limited to 6 visits per claim, except when the attending doctor practices in a remote location where no licensed, registered physical therapist is available.
- After six visits, the patient must be referred to a licensed, registered physical therapist or physiatrist for such treatment. Refer to WAC 296-21-290 for further information.

1044M Physical medicine modality(ies) and/or procedure(s) by the attending doctor who is not board qualified or certified in physical medicine and rehabilitation. Limited to first six visits, except when a doctor practices in a remote area $33.98

PHYSICAL AND OCCUPATIONAL THERAPY

This section applies to all physical and occupational therapists. For specific information on surgical dressings dispensed for home use, refer to WAC 296-23-220 or see "Supplies, Materials and Bundled Services" later in this section.

Coding and Payment Policies

Physical and occupational therapists should use the appropriate physical medicine CPT codes 97001-97799, with the exceptions noted later in this section. In addition, physical and occupational therapists should bill the appropriate covered HCPCS codes for miscellaneous materials and supplies.

Only one unit per day is payable for supervised modalities and those therapeutic procedures which do not list a specific time increment in their description.

If more than one patient is treated at the same time in a group setting, use CPT code 97150, group therapeutic procedures.

CPT code 97010, application of hot or cold packs, is bundled for all providers.

The codes for materials and supplies dispensed for home use and which do not have a fee listed will be paid at their **acquisition cost.** Invoices must be retained in the provider files. Copies must be submitted with the bill for supplies costing $150.00 or more. **Sales tax is not a separately billable item. The total charge for the supply or services should include sales tax when applicable.** Most supplies and materials used in the course of treatment are bundled into the treatment and are not payable separately. See **Appendix C** for a list of bundled supplies.

Daily Maximum for Services

The daily maximum allowable fee is $99.00 for physical and occupational therapy services (as described in WACs 296-23-220 and 296-23-230). The daily maximum applies to CPT codes 64550, and 97001-97799 when performed for the same patient for the same date of service. If both physical and occupational therapy services are provided on the same day, the daily maximum applies ***once*** for each provider type.

The daily maximum allowable fee does not apply to performance based physical capacities examinations (PCEs), work hardening services or job/pre-job accommodation consultation services billed with local codes.

Physical Therapy Evaluation

- CPT code 97001 is used to report the initial evaluation before the plan of care is established by the physician or **physical therapist**. This evaluation is for the purpose of evaluating the patient's condition and establishing the plan of care.

- CPT code 97002 is used to report the re-evaluation of a patient who has been under a plan of care established by the physician or **physical therapist**. This evaluation is for the purpose of re-evaluating the patient's condition and revising the plan of care under which the patient is being treated.

Occupational Therapy Evaluation

- CPT code 97003 is used to report the initial evaluation before the plan of care is established by the physician or **occupational therapist**. This evaluation is for the purpose of evaluating the patient's condition and establishing the plan of care.
- CPT code 97004 is used to report the re-evaluation of a patient who has been under a plan of care established by the physician or **occupational therapist**. This evaluation is for the purpose of re-evaluating the patient's condition and revising the plan of care under which the patient is being treated.

Transcutaneous Electrical Nerve Stimulators (TENS)

TENS units and supplies for State Fund injured workers are provided under contract. All providers who prescribe TENS units for State Fund injured workers must use the department's contracted vendor.

- TENS use requires prior authorization from the insurer. Please call the Provider Hotline at 1-800-848-0811 for authorization.
- The department allows the initial TENS application and training by a physical therapist or other qualified provider ***only once per claim***. Use CPT code 64550.
- An initial 30-day evaluation period is required. If the TENS is beneficial for the injured worker, a three-month rental period may be approved. One additional three-month rental extension may be granted. At the end of six months, a request for purchase will be considered upon review by the insurer. Refer to the department's Provider Bulletin on TENS for more information about rental and purchase for State Fund claims.
- The department's contracted vendor and providers treating Self-Insured workers should use the appropriate HCPCS codes to bill for TENS units and supplies.
- Sales tax and delivery charges are not separately payable, and should be included in the total charge for the TENS unit and supplies.

Wound Debridement

Therapists may not bill the surgical CPT codes for wound debridement. Therapists must bill CPT 97601 or 97602 when performing wound debridement that exceeds what is incidental to a therapy (e.g. whirlpool).

Wound dressings and supplies used in the office are bundled and are not separately payable. Wound dressings and supplies sent home with the patient for self-care can be billed with HCPCS codes appended with local modifier -1S. See the "Supplies, Materials and Bundled Services" section for more information.

Non-Covered Services

Code	Abbreviated Description
CPT 97033	Iontophoresis, each 15 min
CPT 97545*	Work hardening/conditioning
CPT 97546*	each additional hour
HCPCS Q0086	PT evaluation/treatment, per visit

* Work hardening services are paid only to approved providers with local codes.

Non-Covered Items and Services

The department makes general policy decisions, called medical coverage decisions, to ensure quality of care and prompt treatment of workers. Medical coverage decisions include or exclude a specific health care service as a covered benefit. See WAC 296-20-02700. Lists of non-covered services can be found in Appendix E of this section, throughout the *Medical Aid Rules and Fee Schedules*, and in the *Provider Bulletins* For examples see WAC 296-20-03002 and WAC 296-20-1102. In addition, the following are examples of non-covered items:

- Acupuncture
- Intradiscal Electrothermal Treatment (IDET)
- Heat and cold devices for home use
- Cervical, lumbar and other types of pillows
- Home exercise equipment. Possible exceptions may be made in the case of catastrophic injury, but are subject to review and require prior authorization from the claims manager.
- Home use of muscle stimulators except when preapproved for partial or complete muscle denervation

Biofeedback Services

See "Biofeedback" earlier in this section, and in the "Specialty and Administrative Services" section.

Bundled Items

Refer to **Appendices B and C** in this section for information about services and supplies which are considered bundled and are not payable separately. The following are examples of bundled items:

- CPT code 97010, application of hot or cold packs
- Electrodes and gel
- Activity supplies used in work hardening such as leather and wood
- Exercise balls
- Thera-taping
- Wound dressing materials used during an office visit and/or physical therapy treatment

MASSAGE THERAPISTS

Massage therapists will be paid for CPT code 97124 for all forms of massage therapy, regardless of the technique used. The department will not pay massage therapists for additional codes.

Massage therapists should bill their usual and customary fee and designate the duration of the massage therapy treatment. Massage is a physical medicine service and is subject to the daily maximum allowable amount of $99.00.

The application of hot or cold packs (CPT code 97010), anti-friction devices, and lubricants (e.g. oils, lotions, emollients, etc.) are bundled into the massage therapy service and are not payable separately.

Refer to WAC 296-23-250 for additional information.

MISCELLANEOUS

Electrocardiograms (EKG)

Separate payment is allowed for electrocardiograms (CPT codes 93000, 93010, 93040 and 93042) when a physician's interpretation and report is included. These services may be paid in

conjunction with physician office services. EKG tracings without physician interpretation and report (CPT codes 93005 and 93041) are not payable in addition to physician office services.

Transportation of portable EKG equipment to a facility or other patient location (HCPCS code R0076) is bundled into the EKG procedure and is not separately payable.

Ventilator Management Services

No payment will be made for ventilator management services (CPT codes 94656, 94657, 94660 and 94662) when a hospital E/M service is reported on the same day by the same provider. The restricted E/M codes include CPT codes 99217-99220, 99221-99236 and 99251-99275. Physicians will be paid for either the appropriate ventilation management code **or** the E/M service, but not both. If a physician bills a ventilator management code on the same day as an E/M service, payment will be made for the E/M service and not for the ventilation management code.

After Hours, Evening and Holiday Services

CPT codes 99050 (medical services after hrs), 99052 (medical services at night) and 99054 (medical services, unusual hrs) are payable only when services are provided outside the usual hours of operation. The medical record must document the medical necessity and urgency of the service. *Only one of these codes will be paid per patient per day.*

SUPPLIES, MATERIALS AND BUNDLED SERVICES

Services and supplies provided must be medically necessary and must be prescribed by an approved provider for the direct treatment of a covered condition.

CPT code 99070, which represents miscellaneous supplies and materials provided by the physician, will not be paid. Providers must bill specific HCPCS or local codes for supplies and materials provided during an office visit or with other office services.

Supply codes that do not have a fee listed will be paid at their *acquisition cost*. The acquisition cost equals the wholesale cost plus shipping and handling and sales tax. These items should be billed together as one charge. For taxable items, an itemized listing of the cost plus sales tax may be attached to the bill, but is not required.

Wholesale invoices for all supplies and materials must be retained in the provider's office files for a minimum of five years. A provider must submit a hard copy of the wholesale invoice to the department or Self-Insurer when an individual supply costs $150.00 or more, or upon request. The insurer may delay payment of the provider's bill if the insurer has not received this information.

Supplies used in the course of an office visit are considered bundled and are not payable separately. Fitting fees are bundled into the office visit, or into the cost of any durable medical equipment, and are not payable separately.

Sales tax and shipping and handling charges are not separately payable, and should be included in the total charge for the supply. An itemized statement showing net price plus tax may be attached to bills, but is not required.

BUNDLED SERVICES

Under the fee schedules, some services are considered "bundled" into the cost of other procedures and will not be separately paid. See WAC 296-20-01002 for the definition of a "bundled code." Bundled services are listed with "Bundled" in the dollar value column in the "CPT & HCPCS Fee Schedule" section. They are also listed in **Appendix B** in the "Washington RBRVS Payment Policies" section.

BUNDLED SUPPLIES

Under the fee schedules, many supply items are considered "bundled" into the cost of other services (associated office visits or procedures) and will not be paid separately. See WAC 296-20-01002 for the definition of a "bundled code." Bundled supplies are listed with "Bundled" in the dollar value column in the "CPT & HCPCS Fee Schedule" section. They are also listed in **Appendix C** in the "Washington RBRVS Payment Policies" section.

CASTING MATERIALS

Providers should bill for casting materials with HCPCS codes A4580 and A4590. The department no longer accepts local codes 2978M through 2987M. **No payment will be made for the use of a cast room**. Use of a cast room is considered part of a provider's practice expense.

CATHETERIZATION

Separate payment is allowed for placement of a temporary indwelling catheter when performed in a physician's office and used to treat a temporary obstruction. To bill for this service, use HCPCS code G0002.

Payment for the service is not allowed when the procedure is performed on the same day as, or during the postoperative period of, a major surgical procedure that has a follow-up day period.

For catheterization to obtain specimen(s) for lab tests, see "Pathology and Laboratory Services" in the "Specialty and Administrative Services" section.

SURGICAL TRAYS AND SUPPLIES USED IN THE PHYSICIAN'S OFFICE

The department or Self-Insurer follows HCFA's guidelines for determining if a procedure warrants separate additional payment for a surgical tray. HCFA generally assumes that the cost of the sterile trays is incorporated into the practice expense portion of payment for procedures.

Separate additional payment will be allowed for surgical trays only when they are used in conjunction with certain procedures performed in the physician's office. When one of these procedures is performed in the physician's office, the provider may report HCPCS code A4550, "surgical trays." HCPCS codes A4263, A4300 and G0025 for supplies are paid using these same guidelines. A list of procedure codes for which a separate surgical tray or supply code may be payable can be found in **Appendix D** at the end of this section. *Please note special instructions for CPT codes 36533, 68761 and 95028.*

HCFA is gradually updating the practice expense components of the Relative Value Units (RVUs) over a four-year period. This action incorporates the surgical supply expense into the practice expense component of pertinent CPT procedures. At the end of the four-year transition period, the surgical supply expense will be fully incorporated into the practice expense portion of the fees for CPT surgical codes. As a result, the fees paid for HCPCS codes A4263, A4300, A4550 and G0025 will be reduced and phased out accordingly. The first price reductions for these codes occurred in 1999.

SURGICAL DRESSINGS DISPENSED FOR HOME USE

The policy for surgical dressings dispensed *for home use* is based on HCFA's policy. If a health services provider applies surgical dressings during the course of a procedure or office or clinic visit, the cost is included in the practice expense component of the Relative Value Unit (overhead) for that provider, and no separate payment is allowed.

Primary and secondary surgical dressings dispensed by health services providers *for home use* are payable *at acquisition cost* when all of the following conditions are met:

- They are dispensed to a patient for home care of a wound, and
- They are medically necessary, and
- The wound is due to an accepted work related condition.

Primary Surgical Dressings

Primary surgical dressings are therapeutic or protective coverings applied directly to wounds or lesions either on the skin or caused by an opening to the skin. Examples of primary surgical dressings include items such as Telfa, adhesive strips for wound closure, petroleum gauze, etc.

Secondary Surgical Dressings

Secondary surgical dressings are materials that serve a therapeutic or protective function, and that are needed to secure a primary dressing. Examples of secondary surgical dressings include items such as adhesive tape, roll gauze, binders, and disposable compression material etc. It does *not* include items such as elastic stockings, support hose, pressure garments etc. These items must be billed with the appropriate HCPCS or local codes.

In order to receive payment for dressings, providers must bill the appropriate HCPCS code for each dressing item, **along with local modifier -1S** for each item.

Surgical dressing supplies and codes billed without local modifier -1S, are considered bundled and will not be paid. The department or Self-Insurer may audit the use of these modifiers to ensure appropriate usage and billing.

HOT AND COLD PACKS OR DEVICES

Application of hot or cold packs (CPT code 97010) is bundled for all providers. WAC 296-20-1102 prohibits payment for heat devices for home use (this includes heating pads). These devices are either bundled or not covered--see **Appendices B, C and E.**

ELECTRICAL STIMULATORS

Providers using stimulators in the office setting may bill professional services for application of stimulators with the CPT physical medicine codes, when such application is within the provider's scope of practice. Refer to the department's Provider Bulletin on TENS for more information about rental and purchase for State Fund claims.

The following devices or supplies are intended for home use or surgical implantation. Please note the coverage status.

HCPCS Code	Description	Coverage Status
A4595	TENS supplies	For State Fund claims: Payable only to the department's contracted vendor. For Self-Insured claims: Payable to DME suppliers.
A4630	Replacement batteries	
E0720	TENS, two lead, localized stimulation	
E0730	TENS, four lead, larger area, multiple nerve stimulation	
A4365	Adhesive remover	Bundled for physician office use. Payable for home use only.
A4455	Adhesive remover wipe	
A4556	Electrodes	
A4557	Lead wires	
A4558	Conductive paste or gel	
A5119	Skin barrier wipes	
A6250	Skin seal protect moisturizer	
E0745	Neuromuscular stimulator electronic shock unit	Covered for home use for muscle denervation only. Prior authorization is required.
E0747	Osteogenic stimulator, electrical, non-invasive, other than spinal applications	Prior authorization is required.
E0749	Osteogenic stimulator, electrical (surgically implanted)	Authorization is subject to utilization review.
E0760	Osteogenesis stimulator, low intensity, ultrasound, non-invasive	Prior authorization is required. For appendicular skeleton only (not the spine).
E0731	Form fitting conductive garment for TENS or NMES	Not covered.
E0740	Incontinence treatment system	
E0744	Neuromuscular stimulator for scoliosis	
E0748	Osteogenic stimulator, electrical, non-invasive, spinal applications	
E0753	Implantable neurostimulator electrodes, per group of four	
E0755	Electronic salivary reflex stimulator	

MEDICATION ADMINISTRATION

IMMUNIZATIONS

Refer to WAC 296-20-03005 for authorization and requirements for work related exposure to an infectious disease. If authorized, immunization materials are payable. Immunization administration codes (CPT codes 90471 and 90472) are payable in addition to the immunization materials code(s). Add-on CPT code 90472 has a maximum daily fee of $5.44. An E/M code is not payable in addition to the immunization administration service, unless it is performed for a separately identifiable purpose and billed with a -25 modifier.

IMMUNOTHERAPY

Professional services for the supervision and provision of antigens for allergen immunotherapy must be billed as component services. Complete service codes (CPT codes 95120 - 95134) will not be paid. The provider must bill as appropriate, one of the injection codes (CPT codes 95115 or 95117) and one of the antigen/antigen preparation codes (CPT codes 95145-95149, 95165 or 95170).

INFUSION THERAPY SERVICES AND SUPPLIES FOR RBRVS PROVIDERS

Prior authorization is required for any scheduled or ongoing infusion therapy services (including supplies) performed in the office, clinic or home, regardless of who performs the service (e.g. physicians, nurses, IV infusion therapy company, pharmacy or home health agency). Refer to the "Specialty and Administrative Services" section for further information on home infusion therapy.

Outpatient infusion therapy services are allowed without prior authorization when medically necessary to treat urgent or emergent care situations that arise in an office or clinic. In these situations, infusion therapy services are payable to physicians, ARNPs, and PAs (CPT codes 90780 and 90781). HCPCS code Q0081 is not payable. Intravenous or intra-arterial therapeutic or diagnostic injection codes (CPT codes 90783 and 90784) will not be paid separately in conjunction with the IV infusion codes (CPT codes 90780 and 90781). Providers will be paid for E/M office visits (CPT codes 99201-99215) in conjunction with infusion therapy only if the services provided meet the service code definitions.

Billing instructions for non-pharmacy providers are located in "Injectable Medications" later in this section. Drugs supplied by a pharmacy should be billed on pharmacy forms with national drug codes (NDCs, or UPCs if no NDC is available).

Infusion therapy supplies and related durable medical equipment such as infusion pumps are not separately payable for RBRVS providers. Payment for these items is bundled into the fee paid for the professional service. If rental or purchase of an infusion pump is medically necessary to treat a patient in the home, refer to the "Specialty and Administrative Services" section for further information.

The department does ***not*** cover implantable infusion pumps and supplies (HCPCS codes A4220, E0782, E0783 and E0785). The department also does ***not*** cover the implantation of epidural or intrathecal catheters, including their revision, repositioning, replacement, or removal (CPT codes 62350-62368).

Note: Appeals for exceptions to this payment policy may be made to the department's medical director ***and may be granted only by the medical director*** if catastrophic conditions exist (e.g. infusion of Baclofen for severe spasticity in quadriplegia).

Placement of non-implantable epidural or subarachnoid catheters for single or continuous injection of medications are covered services with CPT codes 62310-62319, 62281-62284 and 62290-62294

Intrathecal and epidural infusions of any substance other than anesthetic or contrast material are not covered (per WAC 296-20-03002). Infusion of any opiates and their derivatives (natural, synthetic or semi-synthetic) are not covered unless they are part of providing anesthesia, short term post operative pain management (up to 48 hours post discharge), or unless medically necessary in emergency situations (per WAC 296-20-03014). No exceptions to this payment policy will be granted.

INJECTIONS, THERAPEUTIC OR DIAGNOSTIC

Professional services associated with therapeutic or diagnostic injections (CPT code 90782 or 90788), are payable along with the appropriate HCPCS "J" code for the drug, as long as no E/M office visit service (CPT codes 99201-99215) is provided on the same day. If an E/M office visit service is provided on the same day as an injection, providers will be paid only the E/M service and the appropriate HCPCS "J" code for the drug. Providers must document the name, strength, dosage and quantity of the drugs administered in the medical record.

Intra-arterial and intravenous diagnostic and therapeutic injection services (CPT codes 90783 and 90784) may be billed separately, and are payable if they are not provided in conjunction with IV infusion therapy services (CPT codes 90780 and 90781).

Note: Injections of narcotics or analgesics are not permitted or paid in the outpatient setting except on an emergency basis per WAC 296-20-03014 (6), or for pain management related to outpatient surgical procedures and dressing and cast changes for severe soft tissue injuries, burns or fractures.

"Dry needling" is considered a variant of trigger point injections with medications. Dry needling is a technique where needles are inserted (no medications are injected) directly into trigger point locations as opposed to the distant points or meridians used in acupuncture. The department does not cover acupuncture services (WAC 296-20-03002). Dry needling of trigger points should be billed using only the trigger point injection code (CPT code 20550). Dry needling follows the same rules as trigger point injections in WAC 296-20-03001 (14).

INJECTABLE MEDICATIONS

Providers should use the "J" codes for injectable drugs that are administered **during** an E/M office visit or other procedure. The J codes are not intended for self-administered medications.

When billing for a non-specific injectable drug, the name, strength, dosage and quantity of drug administered or dispensed must be noted on the bill as well as documented in the medical record.

Providers should bill their acquisition cost for the drugs. Department fees for injectable medications are based on the Average Wholesale Prices (AWP). Payment is made according to the published fee schedule amount, or the billed charge for the covered drug(s), whichever is less.

HYALURONIC ACID FOR OSTEOARTHRITIS OF THE KNEE REHABILITATION

See Provider Bulletin 98-10 for more information about the use of hyaluronic acid for osteoarthritis of the knee. Only the following local codes should be billed for these services:

3020A	Hyalgan including injection procedure, per injection (limited to 5 injections per knee joint per claim)	$144.00
3040B	Synvisc including injection procedure, per injection (limited to 3 injections per knee joint per claim)	$225.13

The correct side of body modifier (-RT or -LT) will be required for authorization and billing. If bilateral procedures are required, both modifiers should be authorized and each should be billed as a separate line item.

The HCPCS codes for hyaluronic acid (HCPCS codes J7315 and J7320) are not covered and will not be paid. CPT injection procedure code 20610 will not be paid on the same date as the above local codes.

NON-INJECTABLE MEDICATIONS

Providers may administer oral or non-injectable medications during office procedures or dispense them for short-term use until the worker can have their prescription filled at a pharmacy. In these cases, providers should bill the distinct "J" code which describes the medication. If no distinct J code describes the medication, the most appropriate non-specific HCPCS code listed below should be used:

J3535 Drug administered through a metered dose inhaler
J7599 Immunosuppressive drug, not otherwise classified
J7699 Inhalation solution administered though DME, not otherwise specified
J7799 Other than inhalation drug administered though DME, not otherwise specified
J8499 Prescription drug, oral, non-chemotherapeutic, not otherwise specified
J8999 Prescription drug, oral, chemotherapeutic, not otherwise specified.

The name, strength, dosage and quantity of drug administered or dispensed must be noted on the bill as well as documented in the medical record. No payment will be made for pharmaceutical samples.

HIV PROPHYLAXIS

Insurers will pay for the initial prophylactic drug kit for post HIV exposure when it is dispensed by the treating physician. The kit allows prophylaxis to begin immediately and gives the worker time to get a routine prescription filled. Each kit contains a two day supply of Combivir and Viracept, or other appropriate antiviral drugs. A maximum of two kits per exposure are payable. A claim must be filed for a documented HIV exposure at work for the kit(s) to be payable. Providers should bill the following local code for the HIV drug kit:

3060A HIV exposure initial treatment kit $130.65

RBRVS MODIFIERS

Only the modifiers that affect payment are listed in this section. Refer to current CPT and HCPCS books for complete modifier descriptions and instructions.

CPT MODIFIERS

-22 Unusual services
Procedures with this modifier may be individually reviewed prior to payment. A report is required for this review. Payment varies based on the report submitted.

-24 Unrelated evaluation and management (E/M) services by the same physician during a postoperative period
Used to indicate an evaluation and management service unrelated to the surgical procedure was performed during a postoperative period. *Documentation must be submitted with the billing form when this modifier is used.* Payment is made at one hundred percent of the fee schedule level or billed charge, whichever is less.

-25 Significant, separately identifiable evaluation and management (E/M) service by the same physician on the day of a procedure
Payment is made at one hundred percent of the fee schedule level or billed charge, whichever is less. See global surgery rules, osteopathic manipulative treatment policy, and chiropractic physician services.

-26 Professional component
Certain procedures are a combination of the professional (-26) and technical (-TC) components. This modifier should be used when only the professional component is performed. When a global service is performed, neither the -26 nor the -TC modifier should be used. Refer to the HCPCS modifier section for the use of the -TC modifier.

-50 Bilateral surgery
The bilateral modifier identifies cases where a procedure typically performed on one side of the body is, in fact, performed on both sides of the body. Payment is made at one hundred fifty percent of the global surgery fee for the procedure. Providers must bill using two line items on the bill form. The modifier -50 should be applied to the second line item.

-51 Multiple surgery
For procedure codes that represent multiple surgical procedures, payment is made based on the fee schedule allowance associated with that code. Refer to the global surgery rules for additional information.

-52 Reduced services
Payment is made at the fee schedule level or billed charge, whichever is less.

-53 Discontinued services
HCFA has established reduced RVUs for CPT code 45378 when billed with modifier -53. The department prices this code-modifier combination according to those RVUs.

-54 Surgical care only *
When one physician performs a surgical procedure and another provides preoperative and/or postoperative management

-55 Postoperative management only *
When one physician performs the postoperative management and another physician has performed the surgical procedure.

-56 Preoperative management only *

When one physician performs the preoperative care and evaluation and another physician performs the surgical procedure.

* **Providers providing less than the global surgical package should use modifiers -54, -55, and -56.** These modifiers are designed to ensure that the sum of all allowances for all practitioners who furnished parts of the services included in a global surgery fee does not exceed the total amount of the payment that would have been paid to a single practitioner under the global fee for the procedure. The payment policy pays each physician directly for that portion of the global surgery services provided to the claimant.

-57 Decision for surgery

Used only when the decision for surgery was made during the preoperative period of a surgical procedure with a global surgery follow-up period. It should not be used with visits furnished during the global period of minor procedures (0-10 day global period), unless the purpose of the visit is a decision for major surgery. Separate payment should be made even if the visit falls within the global surgery period. No separate documentation is needed when submitting a billing form with this modifier.

-60 Altered Surgical Field

Procedures with this modifier may be individually reviewed prior to payment. A report is required for this review. Payment varies based on the report submitted.

-62 Two surgeons

For surgery requiring the skills of two surgeons (usually with a different specialty), each surgeon is paid at 62.5% of the global surgical fee. No payment is made for an assistant-at-surgery in these cases.

-66 Team surgery

Used when highly complex procedures are carried out by a surgical team. This may include the concomitant services of several physicians, often of different specialties; other highly skilled, specially trained personnel; and various types of complex equipment. Procedures with this modifier are reviewed and priced on an individual basis. Supporting documentation is required for this review.

-78 Return to the operating room for a related procedure during the postoperative period

Payment is made at one hundred percent of the fee schedule level or billed amount, whichever is less.

-79 Unrelated procedure or service by the same physician during the postoperative period

Use of this modifier allows separate payment for procedures not associated with the original surgery. Payment is made at one hundred percent of the fee schedule level or billed amount, whichever is less.

-80 Assistant surgeon *

-81 Minimum assistant surgeon *

-82 Assistant surgeon (when qualified resident surgeon not available) *

* **Assistant Surgeon Modifiers**. Physicians who assist the primary physician in surgery should use modifiers -80, -81 or -82 depending on the medical necessity. Payment for procedures with these modifiers is made at the billed charge or twenty percent of the global surgery amount for the procedure, whichever is less. Refer to the assistant surgeon indicator in the "CPT & HCPCS Fee Schedule" section to determine if assistant surgeon fees are payable.

-91 Repeat clinical diagnostic laboratory test performed on the same day to obtain subsequent reportable test values(s) (separate specimens taken in separate encounters)
Payment will be made for repeat test(s) performed for the same patient on the same day when specimen(s) have been taken from separate encounters. Test(s) normally performed as a series, e.g. glucose tolerance test do not qualify as separate encounters. The medical necessity for repeating the test(s) must be documented in the patient record.

-99 Multiple modifiers
This modifier should only be used when two or more modifiers affect payment. Payment is based on the policy associated with each individual modifier that describes the actual services performed. For billing purposes, only modifier -99 should go in the modifier column, with the individual descriptive modifiers that affect payment listed elsewhere on the billing form.

HCPCS MODIFIERS

-GT Teleconsultations via interactive audio and video telecommunication systems
See "Washington RBRVS Payment Policy" section on teleconsultations for more detail.

-LT Left side
Although this modifier does not affect payment, it should be used when billing for bilateral services. This will help reduce duplicate bills and minimize payment delays.

-RT Right side
Although this modifier does not affect payment, it should be used when billing for bilateral services. This will help reduce duplicate bills and minimize payment delays.

-SG Ambulatory surgical center (ASC) facility service
Bill the appropriate CPT surgical code(s) adding this modifier -SG to each surgery code.

-TC Technical component
Certain procedures are a combination of the professional (-26) and technical (-TC) components. This modifier should be used when only the technical component is performed. When a global service is performed, neither the -26 nor -TC modifier should be used. Refer to the CPT modifier section for the use of the -26 modifier.

LOCAL MODIFIERS

-1M Surgical suite/facility
Bill the appropriate CPT surgical code(s) adding this modifier -1M to each surgery code. See Provider Bulletin 94-13 for coverage and fee information.

-1R Radiology consult
For radiology consultation services bill the specific x-ray code along with this modifier -1R. For example, if a consultation is made on a chest x-ray, single view, frontal, the provider should bill CPT code 71010-1R. Payment is made at the professional component rate.

-1S Surgical dressings for home use
Bill the appropriate HCPCS code for each dressing item using this modifier -1S for each item. Use this modifier to bill for surgical dressing supplies dispensed for home use. See "Supplies, Material and Bundled Services" earlier in this section for more information.

APPENDIX A
ENDOSCOPY FAMILIES

Refer to a current CPT book for complete coding information.

Base	Family
29815	29819, 29820, 29821, 29822, 29823, 29825 and 29826
29830	29834, 29835, 29836, 29837 and 29838
29840	29843, 29844, 29845, 29846 and 29847
29860	29861, 29862 and 29863
29870	29871, 29874, 29875, 29876, 29877, 29879, 29880, 29881, 29882, 29883, 29884, 29885, 29886 and 29887
31505	31510, 31511, 31512 and 31513
31525	31527, 31528, 31529, 31530, 31535, 31540, 31560 and 31570
31526	31531, 31536, 31541, 31561 and 31571
31575	31576, 31577, 31578 and 31579
31622	31625, 31628, 31629, 31630, 31631, 31635, 31640, 31641 and 31645
43200	43202, 43204, 43205, 43215, 43216, 43217, 43219, 43220, 43226, 43227 and 43228
43235	43231, 43232, 43239, 43241, 43242, 43243, 43244, 43245, 43246, 43247, 43249, 43250, 43251, 43255, 43256, 43258 and 43259
43260	43240, 43261, 43262, 43263, 43264, 43265, 43267, 43268, 43269, 43271, and43272
44360	44361, 44363, 44364, 44365, 44366, 44369, 44370, 44372 and 44373
44376	44377, 44378 and 44379
44388	44389, 44390, 44391, 44392, 44393, 44394 and 44397
45300	45303, 45305, 45307, 45308, 45309, 45315, 45317, 45320, 45321 and 45327
45330	45331, 45332, 45333, 45334, 45337, 45338, 45339 and 45345
45378	45379, 45380, 45382, 45383, 45384, 45385and 45387
46600	46604, 46606, 46608, 46610, 46611, 46612, 46614 and 46615
47552	47553, 47554, 47555 and 47556
49320	38570, 49321, 49322, 49323, 58550, 58551, 58660, 58661, 58662, 58670, 58671, 58672 and 58673
50551	50555, 50557, 50559 and 50561
50570	50572, 50574, 50575, 50576, 50578 and 50580
50951	50953, 50955, 50957, 50959 and 50961
50970	50974 and 50976
52000	52007, 52010, 52204, 52214, 52224, 52250, 52260, 52265, 52270, 52275, 52276, 52277, 52281, 52282, 52283, 52285, 52290, 52300, 52301, 52305, 52310, 52315, 52317 and 52318
52005	52320, 52325, 52327, 52330, 52332, 52334, 52341, 52342, 52343 and 52344
52351	52345, 52346, 52352, 52353, 52354 and 52355
57452	57454 and 57460
58555	58558, 58559, 58560, 58561, 58562 and 58563

APPENDIX B
BUNDLED SERVICES

Do not rely solely on the descriptions given in the appendices for complete coding information. Refer to a current CPT or HCPCS book for complete coding information.

CPT Code	Abbreviated Description
15850	Removal of sutures
20930	Spinal bone allograft
20936	Spinal bone autograft
22841	Insert spine fixation device
43752	Nasal/orogastic w/stent
78890	Nuclear medicine data proc
78891	Nuclear med data proc
90885	Psy evaluation of records
90887	Consultation with family
90889	Preparation of report
92352	Special spectacles fitting
92353	Special spectacles fitting
92354	Special spectacles fitting
92355	Special spectacles fitting
92358	Eye prosthesis service
92371	Repair & adjust spectacles
92531	Spontaneous nystagmus study
92532	Positional nystagmus study
92533	Caloric vestibular test
92534	Optokinetic nystagmus
93770	Measure venous pressure
94150	Vital capacity test
94760	Measure blood oxygen level
94761	Measure blood oxygen level

CPT Code	Abbreviated Description
96545	Provide chemotherapy agent
97010	Hot or cold packs therapy
99000	Specimen handling
99001	Specimen handling
99002	Device handling
99024	Postop follow-up visit
99025	Initial surgical evaluation
99056	Non-office medical services
99058	Office emergency care
99078	Group health education
99090	Computer data analysis
99100	Special anesthesia service
99116	Anesthesia with hypothermia
99135	Special anesthesia procedure
99140	Emergency anesthesia
99141	Sedation, iv/im or inhalant
99142	Sedation, oral/rectal/nasal
99173	Visual screening test
99358	Prolonged serv, w/o contact
99359	Prolonged serv, w/o contact
99374	Home health care supervision
99377	Hospice care supervision
99379	Nursing fac care supervision

HCPCS Code	Abbreviated Description
A9900	Supply/accessory/service
G0008	Admin influenza virus vac
G0009	Admin pneumococcal vaccine
G0010	Admin hepatitis b vaccine
G0102	Prostate ca screening; dre
G0172	Partial hosp prog service
L9900	O&P supply/accessory/service
R0076	Transport portable EKG

APPENDIX C
BUNDLED SUPPLIES

Do not rely solely on the descriptions given in the appendices for complete coding information. Refer to a current CPT or HCPCS book for complete coding information.

Note: Items with an asterisk (*) on the following list are considered prosthetics when used for a **permanent** condition. They may be paid separately for permanent conditions if they are provided in the physician's office. They are not considered prosthetics if the condition is acute or temporary.

Examples are Foley catheters and accessories for permanent incontinence or ostomy supplies for permanent conditions. The Foley catheter used to obtain a urine specimen, used after surgery, or used to treat an acute obstruction would not be paid separately because it is treating a temporary problem. If a patient had an indwelling Foley catheter for permanent incontinence, and a problem developed which required the physician to replace the Foley, then the catheter would be considered a prosthesis and would be paid separately.

CPT Code	Abbreviated Description
97010	Hot or cold packs therapy
99070	Special supplies
99071	Patient education materials

HCPCS Code	Abbreviated Description
A4206	1 CC sterile syringe&needle
A4207	2 CC sterile syringe&needle
A4208	3 CC sterile syringe&needle
A4209	5+ CC sterile syringe&needle
A4211	Supp for self-adm injections
A4212	Non coring needle or stylet
A4213	20+ CC syringe only
A4214	30 CC sterile water/saline
A4215	Sterile needle
A4244	Alcohol or peroxide per pint
A4245	Alcohol wipes per box
A4246	Betadine/phisohex solution
A4247	Betadine/iodine swabs/wipes
A4253	Blood glucose/reagent strips
A4256	Calibrator solution/chips
A4258	Lancet device each
A4259	Lancets per box
A4262	Temporary tear duct plug
A4265	Paraffin
A4270	Disposable endoscope sheath
A4301	Implantable access syst perc
A4305	Drug delivery system >=50 ML

HCPCS Code	Abbreviated Description
A4306	Drug delivery system <=5 ML
A4310	Insert tray w/o bag/cath
A4311	Catheter w/o bag 2-way latex
A4312	Cath w/o bag 2-way silicone
A4313	Catheter w/bag 3-way
A4314	Cath w/drainage 2-way latex
A4315	Cath w/drainage 2-way silcne
A4316	Cath w/drainage 3-way
A4319	Sterile H2O irrigation solut
A4320	Irrigation tray
A4322	Irrigation syringe
A4323	Saline irrigation solution
A4324	Male ext cath w/adh coating
A4325	Male ext cath w/adh strip
A4326*	Male external catheter
A4327*	Fem urinary collect dev cup
A4328*	Fem urinary collect pouch
A4329*	External catheter start set
A4330	Stool collection pouch
A4331	Extension drainage tubing
A4332	Lubricant for cath insertion

HCPCS Code	Abbreviated Description
A4333	Urinary cath anchor device
A4334	Urinary cath leg strap
A4335*	Incontinence supply
A4338*	Indwelling catheter latex
A4340*	Indwelling catheter special
A4344*	Cath indw foley 2 way silicn
A4346*	Cath indw foley 3 way
A4347*	Male external catheter
A4348	Male ext cath extended wear
A4351	Straight tip urine catheter
A4352	Coude tip urinary catheter
A4353	Intermittent urinary cath
A4354	Cath insertion tray w/bag
A4355	Bladder irrigation tubing
A4356*	Ext ureth clmp or compr dvc
A4357*	Bedside drainage bag
A4358*	Urinary leg bag
A4359*	Urinary suspensory w/o leg b
A4361*	Ostomy face plate
A4362*	Solid skin barrier
A4364*	Ostomy/cath adhesive
A4365*	Ostomy adhesive remover wipe
A4367*	Ostomy belt
A4368*	Ostomy filter
A4369*	Skin barrier liquid per oz
A4370*	Skin barrier paste per oz
A4371*	Skin barrier powder per oz
A4372*	Skin barrier solid 4x4 equiv
A4373*	Skin barrier with flange
A4374*	Skin barrier extended wear
A4375*	Drainable plastic pch w fcpl
A4376*	Drainable rubber pch w fcplt
A4377*	Drainable plstic pch w/o fp
A4378*	Drainable rubber pch w/o fp
A4379*	Urinary plastic pouch w fcpl
A4380*	Urinary rubber pouch w fcplt
A4381*	Urinary plastic pouch w/o fp
A4382*	Urinary hvy plstc pch w/o fp
A4383*	Urinary rubber pouch w/o fp
A4384*	Ostomy faceplt/silicone ring
A4385*	Ost skn barrier sld ext wear
A4386*	Ost skn barrier w flng ex wr
A4387*	Ost clsd pouch w att st barr
A4388*	Drainable pch w ex wear barr
A4389*	Drainable pch w st wear barr
A4390*	Drainable pch ex wear convex
A4391*	Urinary pouch w ex wear barr

HCPCS Code	Abbreviated Description
A4392*	Urinary pouch w st wear barr
A4393*	Urine pch w ex wear bar conv
A4394*	Ostomy pouch liq deodorant
A4395*	Ostomy pouch solid deodorant
A4396	Peristomal hernia supprt blt
A4397	Irrigation supply sleeve
A4398*	Ostomy irrigation bag
A4399*	Ostomy irrig cone/cath w brs
A4400*	Ostomy irrigation set
A4402*	Lubricant per ounce
A4404*	Ostomy ring each
A4421*	Ostomy supply misc
A4454	Tape all types all sizes
A4455	Adhesive remover per ounce
A4460	Elastic compression bandage
A4462	Abdmnl drssng holder/binder
A4465	Non-elastic extremity binder
A4470	Gravlee jet washer
A4480	Vabra aspirator
A4556	Electrodes, pair
A4557	Lead wires, pair
A4558	Conductive paste or gel
A4647	Supp- paramagnetic contr mat
A4649	Surgical supplies
A4670	Auto blood pressure monitor
A5051*	Pouch clsd w barr attached
A5052*	Clsd ostomy pouch w/o barr
A5053*	Clsd ostomy pouch faceplate
A5054*	Clsd ostomy pouch w/flange
A5055*	Stoma cap
A5061*	Pouch drainable w barrier at
A5062*	Drnble ostomy pouch w/o barr
A5063*	Drain ostomy pouch w/flange
A5064*	Drain ostomy pouch w/fceplte
A5071*	Urinary pouch w/barrier
A5072*	Urinary pouch w/o barrier
A5073*	Urinary pouch on barr w/flng
A5074*	Urinary pouch w/faceplate
A5075*	Urinary pouch on faceplate
A5081*	Continent stoma plug
A5082*	Continent stoma catheter
A5093*	Ostomy accessory convex inse
A5102*	Bedside drain btl w/wo tube
A5105*	Urinary suspensory
A5112*	Urinary leg bag
A5113*	Latex leg strap
A5114*	Foam/fabric leg strap

HCPCS Code	Abbreviated Description
A5119*	Skin barrier wipes box pr 50
A5121*	Solid skin barrier 6x6
A5122*	Solid skin barrier 8x8
A5123*	Skin barrier with flange
A5126*	Disk/foam pad +or- adhesive
A5131*	Appliance cleaner
A6021	Collagen dressing <=16 sq in
A6022	Collagen drsg>6<=48 sq in
A6023	Collagen dressing >48 sq in
A6024	Collagen dsg wound filler
A6025	Silicone gel sheet, each
A6154	Wound pouch each
A6196	Alginate dressing <=16 sq in
A6197	Alginate drsg >16 <=48 sq in
A6198	alginate dressing > 48 sq in
A6199	Alginate drsg wound filler
A6200	Compos drsg <=16 no border
A6201	Compos drsg >16<=48 no bdr
A6202	Compos drsg >48 no border
A6203	Composite drsg <= 16 sq in
A6204	Composite drsg >16<=48 sq in
A6205	Composite drsg > 48 sq in
A6206	Contact layer <= 16 sq in
A6207	Contact layer >16<= 48 sq in
A6208	Contact layer > 48 sq in
A6209	Foam drsg <=16 sq in w/o bdr
A6210	Foam drg >16<=48 sq in w/o b
A6211	Foam drg > 48 sq in w/o brdr
A6212	Foam drg <=16 sq in w/border
A6213	Foam drg >16<=48 sq in w/bdr
A6214	Foam drg > 48 sq in w/border
A6215	Foam dressing wound filler
A6216	Non-sterile gauze<=16 sq in
A6217	Non-sterile gauze>16<=48 sq
A6218	Non-sterile gauze > 48 sq in
A6219	Gauze <= 16 sq in w/border
A6220	Gauze >16 <=48 sq in w/bordr
A6221	Gauze > 48 sq in w/border
A6222	Gauze <=16 in no w/sal w/o b
A6223	Gauze >16<=48 no w/sal w/o b
A6224	Gauze > 48 in no w/sal w/o b
A6228	Gauze <= 16 sq in water/sal
A6229	Gauze >16<=48 sq in watr/sal
A6230	Gauze > 48 sq in water/salne

HCPCS Code	Abbreviated Description
A6231	Hydrogel dsg<=16 sq in
A6232	Hydrogel dsg>16<=48 sq in
A6233	Hydrogel dressing >48 sq in
A6234	Hydrocolld drg <=16 w/o bdr
A6235	Hydrocolld drg >16<=48 w/o b
A6236	Hydrocolld drg > 48 in w/o b
A6237	Hydrocolld drg <=16 in w/bdr
A6238	Hydrocolld drg >16<=48 w/bdr
A6239	Hydrocolld drg > 48 in w/bdr
A6240	Hydrocolld drg filler paste
A6241	Hydrocolloid drg filler dry
A6242	Hydrogel drg <=16 in w/o bdr
A6243	Hydrogel drg >16<=48 w/o bdr
A6244	Hydrogel drg >48 in w/o bdr
A6245	Hydrogel drg <= 16 in w/bdr
A6246	Hydrogel drg >16<=48 in w/b
A6247	Hydrogel drg > 48 sq in w/b
A6248	Hydrogel drsg gel filler
A6250	Skin seal protect moisturizr
A6251	Absorpt drg <=16 sq in w/o b
A6252	Absorpt drg >16 <=48 w/o bdr
A6253	Absorpt drg > 48 sq in w/o b
A6254	Absorpt drg <=16 sq in w/bdr
A6255	Absorpt drg >16<=48 in w/bdr
A6256	Absorpt drg > 48 sq in w/bdr
A6257	Transparent film <= 16 sq in
A6258	Transparent film >16<=48 in
A6259	Transparent film > 48 sq in
A6260	Wound cleanser any type/size
A6261	Wound filler gel/paste /oz
A6262	Wound filler dry form / gram
A6263	Non-sterile elastic gauze/yd
A6264	Non-sterile no elastic gauze
A6265	Tape per 18 sq inches
A6266	Impreg gauze no h20/sal/yard
A6402	Sterile gauze <= 16 sq in
A6403	Sterile gauze>16 <= 48 sq in
A6404	Sterile gauze > 48 sq in
A6405	Sterile elastic gauze /yd
A6406	Sterile non-elastic gauze/yd
A9900	Supply/accessory/service
E0230	Ice cap or collar
L9900	O&P supply/accessory/service

APPENDIX D
SURGICAL TRAYS AND OTHER PAYABLE SUPPLIES

Surgical trays for the following procedure codes may be payable separately when used in the physician's office. The supply code for these procedures is A4550 unless otherwise specified.

Do not rely solely on the descriptions given in the appendices for complete coding information. Refer to a current CPT book for complete coding information.

CPT Code	Abbreviated Description
19101	Biopsy of breast
19120	Removal of breast lesion
19125	Excision, breast lesion
19126	Excision, addl breast lesion
20200	Muscle biopsy
20205	Deep muscle biopsy
20220	Bone biopsy, trocar/needle
20225	Bone biopsy, trocar/needle
20240	Bone biopsy, excisional
25111	Remove wrist tendon lesion
28290	Correction of bunion
28292	Correction of bunion
28293	Correction of bunion
28294	Correction of bunion
28296	Correction of bunion
28297	Correction of bunion
28298	Correction of bunion
28299	Correction of bunion
32000	Drainage of chest
36533	Insertion of access device(the supply code for this procedure is A4300)
37609	Temporal artery procedure
38500	Biopsy/removal, lymph nodes
43200	Esophagus endoscopy
43202	Esophagus endoscopy, biopsy
43220	Esoph endoscopy, dilation
43226	Esoph endoscopy, dilation
43234	Upper GI endoscopy, exam
43235	Uppr gi endoscopy, diagnosis
43239	Upper GI endoscopy, biopsy
43245	Operative upper GI endoscopy
43247	Operative upper GI endoscopy
43249	Esoph endoscopy, dilation
43250	Upper GI endoscopy/tumor
43251	Operative upper GI endoscopy
43458	Dilate esophagus

CPT Code	Abbreviated Description
45378	Diagnostic colonoscopy
45379	Colonoscopy
45380	Colonoscopy and biopsy
45382	Colonoscopy/control bleeding
45383	Lesion removal colonoscopy
45384	Colonoscopy
45385	Lesion removal colonoscopy
49080	Puncture, peritoneal cavity
49081	Removal of abdominal fluid
52005	Cystoscopy & ureter catheter
52007	Cystoscopy and biopsy
52010	Cystoscopy & duct catheter
52204	Cystoscopy
52214	Cystoscopy and treatment
52224	Cystoscopy and treatment
52234	Cystoscopy and treatment
52235	Cystoscopy and treatment
52240	Cystoscopy and treatment
52250	Cystoscopy and radiotracer
52260	Cystoscopy and treatment
52270	Cystoscopy & revise urethra
52275	Cystoscopy & revise urethra
52276	Cystoscopy and treatment
52277	Cystoscopy and treatment
52282	Cystoscopy, implant stent
52283	Cystoscopy and treatment
52290	Cystoscopy and treatment
52300	Cystoscopy and treatment
52301	Cystoscopy and treatment
52305	Cystoscopy and treatment
52310	Cystoscopy and treatment
52315	Cystoscopy and treatment
57520	Conization of cervix
57522	Conization of cervix
58120	Dilation and curettage
62270	Spinal fluid tap, diagnostic

CPT Code	Abbreviated Description
68761	Close tear duct opening (the supply code for this procedure is A4263)
85095	Bone marrow aspiration
85102	Bone marrow biopsy
95028	Allergy skin tests (the supply code for this procedure is G0025)
96440	Chemotherapy, intracavitary
96445	Chemotherapy, intracavitary
96450	Chemotherapy, into CNS

HCPCS Code	Abbreviated Description
G0105	Colorectal scrn; hi risk ind

APPENDIX E
NON-COVERED CODES AND MODIFIERS

Do not rely solely on the descriptions given in the appendices for complete coding information. Refer to a current CPT or HCPCS book for complete coding information.

NON-COVERED CODES

CPT Code	Abbreviated Description
11975	Insert contraceptive cap
11976	Removal of contraceptive cap
11977	Removal/reinsert contra cap
11980	Implant hormone pellet(s)
17340	Cryotherapy of skin
17360	Skin peel therapy
17380	Hair removal by electrolysis
22520	Percut vertebroplasty thor
22521	Percut vertebroplasty lumb
22522	Percut vertebroplasty addl
31520	Diagnostic laryngoscopy
31601	Incision of windpipe
33140	Heart revascularize (tmr)
36400	Drawing blood
36405	Drawing blood
36406	Drawing blood
36420	Establish access to vein
36440	Blood transfusion service
36450	Exchange transfusion service
36470	Injection therapy of vein
36471	Injection therapy of veins
36488	Insertion of catheter, vein
36490	Insertion of catheter, vein
36510	Insertion of catheter, vein
36660	Insertion catheter, artery
42820	Remove tonsils and adenoids
42825	Removal of tonsils
42830	Removal of adenoids
42835	Removal of adenoids
43842	Gastroplasty for obesity
43843	Gastroplasty for obesity
43846	Gastric bypass for obesity
43847	Gastric bypass for obesity
43848	Revision gastroplasty
44970	Laparoscopy, appendectomy
44979	Laparoscope proc, app
46070	Incision of anal septum
46705	Repair of anal stricture

CPT Code	Abbreviated Description
49495	Repair inguinal hernia, init
49496	Repair inguinal hernia, init
49500	Repair inguinal hernia
49501	Repair inguinal hernia, init
49580	Repair umbilical hernia
49582	Repair umbilical hernia
50541	Laparo ablate renal cyst
50545	Laparo radical nephrectomy
50945	Laparoscopy ureterolithotomy
50947	Laparo new ureter/bladder
50948	Laparo new ureter/bladder
53025	Incision of urethra
54000	Slitting of prepuce
54150	Circumcision
54160	Circumcision
54692	Laparoscopy, orchiopexy
55873	Cryoablate prostate
55970	Sex transformation, M to F
55980	Sex transformation, F to M
58300	Insert intrauterine device
58301	Remove intrauterine device
58321	Artificial insemination
58322	Artificial insemination
58323	Sperm washing
58353	Endometr ablate, thermal
58600	Division of fallopian tube
58605	Division of fallopian tube
58611	Ligate oviduct(s) add-on
58615	Occlude fallopian tube(s)
58970	Retrieval of oocyte
58974	Transfer of embryo
58976	Transfer of embryo
59871	Remove cerclage suture
61000	Remove cranial cavity fluid
61001	Remove cranial cavity fluid
62280	Treat spinal cord lesion
62287	Percutaneous diskectomy
62350	Implant spinal canal cath

CPT Code	Abbreviated Description
62351	Implant spinal canal cath
62355	Remove spinal canal catheter
62360	Insert spine infusion device
62361	Implant spine infusion pump
62362	Implant spine infusion pump
62365	Remove spine infusion device
62367	Analyze spine infusion pump
62368	Analyze spine infusion pump
63650	Implant neuroelectrodes
63655	Implant neuroelectrodes
63660	Revise/remove neuroelectrode
63685	Implant neuroreceiver
63688	Revise/remove neuroreceiver
64614	Destroy nerve, extrem musc
65771	Radial keratotomy
69090	Pierce earlobes
73592	X-ray exam of leg, infant
76012	Percut vertebroplasty fluor
76013	Percut vertebroplasty, ct
76140	X-ray consultation
76885	Echo exam, infant hips
76886	Echo exam, infant hips
78459	Heart muscle imaging (PET)
78491	Heart image (pet), single
78492	Heart image (pet), multiple
78608	Brain imaging (PET)
78609	Brain imaging (PET)
78810	Tumor imaging (PET)
82523	Collagen crosslinks
84591	Assay of nos vitamin
84830	Ovulation tests
86146	Glycoprotein antibody
86683	Hemoglobin, fecal antibody
86910	Blood typing, paternity test
86911	Blood typing, antigen system
87339	H pylori ag, eia
87427	Shiga-like toxin ag, eia
88012	Autopsy (necropsy), gross
88014	Autopsy (necropsy), gross
88016	Autopsy (necropsy), gross
88028	Autopsy (necropsy), complete
88029	Autopsy (necropsy), complete
88400	Bilirubin total transcut
89250	Fertilization of oocyte
89251	Culture oocyte w/embryos
89252	Assist oocyte fertilization
89253	Embryo hatching

CPT Code	Abbreviated Description
89254	Oocyte identification
89255	Prepare embryo for transfer
89256	Prepare cryopreserved embryo
89257	Sperm identification
89258	Cryopreservation, embryo
89259	Cryopreservation, sperm
89260	Sperm isolation, simple
89261	Sperm isolation, complex
89321	Semen analysis
90283	Human ig, iv
90288	Botulism ig, iv
90378	Rsv ig, im
90379	Rsv ig, iv
90476	Adenovirus vaccine, type 4
90477	Adenovirus vaccine, type 7
90581	Anthrax vaccine, sc
90632	Hep a vaccine, adult im
90633	Hep a vacc, ped/adol, 2 dose
90634	Hep a vacc, ped/adol, 3 dose
90636	Hep a/hep b vacc, adult im
90645	Hib vaccine, hboc, im
90646	Hib vaccine, prp-d, im
90647	Hib vaccine, prp-omp, im
90648	Hib vaccine, prp-t, im
90657	Flu vaccine, 6-35 mo, im
90658	Flu vaccine, 3 yrs, im
90659	Flu vaccine, whole, im
90660	Flu vaccine, nasal
90669	Pneumococcal vaccine, ped
90680	Rotovirus vaccine, oral
90690	Typhoid vaccine, oral
90691	Typhoid vaccine, im
90692	Typhoid vaccine, h-p, sc/id
90693	Typhoid vaccine, akd, sc
90700	Dtap vaccine, im
90710	Mmrv vaccine, sc
90719	Diphtheria vaccine, im
90720	Dtp/hib vaccine, im
90721	Dtap/hib vaccine, im
90727	Plague vaccine, im
90744	Hep b vaccine, ped/adol, im
90748	Hep b/hib vaccine, im
90802	Intac psy dx interview
90810	Intac psytx, off, 20-30 min
90811	Intac psytx, 20-30, w/e&m
90812	Intac psytx, off, 45-50 min
90813	Intac psytx, 45-50 min w/e&m

CPT Code	Abbreviated Description
90814	Intac psytx, off, 75-80 min
90815	Intac psytx, 75-80 w/e&m
90823	Intac psytx, hosp, 20-30 min
90824	Intac psytx, hsp 20-30 w/e&m
90826	Intac psytx, hosp, 45-50 min
90827	Intac psytx, hsp 45-50 w/e&m
90828	Intac psytx, hosp, 75-80 min
90829	Intac psytx, hsp 75-80 w/e&m
90845	Psychoanalysis
90846	Family psytx w/o patient
90849	Multiple family group psytx
90857	Intac group psytx
90918	ESRD related services, month
90919	ESRD related services, month
90922	ESRD related services, day
90923	Esrd related services, day
91132	Electrogastrography
91133	Electrogastrography w/test
93530	Rt heart cath, congenital
93531	R & l heart cath, congenital
93532	R & l heart cath, congenital
93533	R & l heart cath, congenital
93740	Temperature gradient studies
93760	Cephalic thermogram
93762	Peripheral thermogram
94650	Pressure breathing (IPPB)
94651	Pressure breathing (IPPB)
94652	Pressure breathing (IPPB)
95120	Immunotherapy, one injection
95125	Immunotherapy, many antigens
95130	Immunotherapy, insect venom
95131	Immunotherapy, insect venoms
95132	Immunotherapy, insect venoms
95133	Immunotherapy, insect venoms
95134	Immunotherapy, insect venoms
95970	Analyze neurostim, no prog
95971	Analyze neurostim, simple
95972	Analyze neurostim, complex
95973	Analyze neurostim, complex
95974	Cranial neurostim, complex
95975	Cranial neurostim, complex
96570	Photodynamic tx, 30 min
96571	Photodynamic tx, addl 15 min
96902	Trichogram
97033	Electric current therapy
97545	Work hardening
97546	Work hardening add-on
97780	Acupuncture w/o stimul
97781	Acupuncture w/stimul
98940	Chiropractic manipulation
98941	Chiropractic manipulation
98942	Chiropractic manipulation
98943	Chiropractic manipulation
99075	Medical testimony
99170	Anogenital exam, child
99295	Neonatal critical care
99296	Neonatal critical care
99297	Neonatal critical care
99298	Neonatal critical care
99381	Prev visit, new, infant
99382	Prev visit, new, age 1-4
99383	Prev visit, new, age 5-11
99384	Prev visit, new, age 12-17
99385	Prev visit, new, age 18-39
99386	Prev visit, new, age 40-64
99387	Prev visit, new, 65 & over
99391	Prev visit, est, infant
99392	Prev visit, est, age 1-4
99393	Prev visit, est, age 5-11
99394	Prev visit, est, age 12-17
99395	Prev visit, est, age 18-39
99396	Prev visit, est, age 40-64
99397	Prev visit, est, 65 & over
99401	Preventive counseling, indiv
99402	Preventive counseling, indiv
99403	Preventive counseling, indiv
99404	Preventive counseling, indiv
99411	Preventive counseling, group
99412	Preventive counseling, group
99420	Health risk assessment test
99429	Unlisted preventive service
99431	Initial care, normal newborn
99432	Newborn care, not in hosp
99433	Normal newborn care/hospital
99435	Newborn discharge day hosp
99436	Attendance, birth
99440	Newborn resuscitation
99450	Life/disability evaluation
99455	Disability examination
99456	Disability examination

HCPCS Code	Abbreviated Description
A0432	PI volunteer ambulance co
A0888	Noncovered ambulance mileage
A4220	Infusion pump refill kit
A4260	Levonorgestrel implant
A4261	Cervical cap contraceptive
A4561	Pessary rubber, any type
A4562	Pessary, non rubber,any type
A4570	Splint
A4580	Cast supplies (plaster)
A4590	Special casting material
A4595	TENS suppl 2 lead per month
A9160	Podiatrist non-covered servi
A9170	Chiropractor non-covered ser
A9190	Misc/expe personal comfort i
A9270	Non-covered item or service
A9300	Exercise equipment
D1320	Tobacco counseling
D9999	Adjunctive procedure
E0200	Heat lamp without stand
E0202	Phototherapy light w/ photom
E0205	Heat lamp with stand
E0210	Electric heat pad standard
E0215	Electric heat pad moist
E0217	Water circ heat pad w pump
E0218	Water circ cold pad w pump
E0220	Hot water bottle
E0225	Hydrocollator unit
E0236	Pump for water circulating p
E0238	Heat pad non-electric moist
E0239	Hydrocollator unit portable
E0249	Pad water circulating heat u
E0500	Ippb all types
E0590	Dispensing fee dme neb drug
E0602	Breast pump
E0720	Tens two lead
E0730	Tens four lead
E0731	Conductive garment for tens
E0740	Incontinence treatment systm
E0744	Neuromuscular stim for scoli
E0748	Elec osteogen stim spinal
E0753	Neurostimulator electrodes
E0755	Electronic salivary reflex s
E0756	Implantable pulse generator
E0757	Implantable RF receiver
E0758	External RF transmitter
E0765	Nerve stimulator for tx n&v

HCPCS Code	Abbreviated Description
E0782	Non-programble infusion pump
E0783	Programmable infusion pump
E0785	Replacement impl pump cathet
E0786	Implantable pump replacement
E0941	Gravity assisted traction de
E0943	Cervical pillow
G0030	PET imaging prev PET single
G0031	PET imaging prev PET multple
G0032	PET follow SPECT 78464 singl
G0033	PET follow SPECT 78464 mult
G0034	PET follow SPECT 76865 singl
G0035	PET follow SPECT 78465 mult
G0036	PET follow cornry angio sing
G0037	PET follow cornry angio mult
G0038	PET follow myocard perf sing
G0039	PET follow myocard perf mult
G0040	PET follow stress echo singl
G0041	PET follow stress echo mult
G0042	PET follow ventriculogm sing
G0043	PET follow ventriculogm mult
G0044	PET following rest ECG singl
G0045	PET following rest ECG mult
G0046	PET follow stress ECG singl
G0047	PET follow stress ECG mult
G0110	Nett pulm-rehab educ; ind
G0111	Nett pulm-rehab educ; group
G0112	Nett; nutrition guid, initial
G0113	Nett; nutrition guid,subseqnt
G0114	Nett; psychosocial consult
G0115	Nett; psychological testing
G0116	Nett; psychosocial counsel
G0125	Lung image (PET)
G0128	CORF skilled nursing service
G0129	Part. Hosp. Prog. Occupa Tx.
G0154	Svcs of skilled nurse under hm hlth, ea 15 min
G0155	Svcs of clin soc wkr under hm hlth, ea 15 min
G0176	OPPS/PHP;activity therapy
G0179	MD recert HHA patient
G0180	MD certification HHA patient
G0181	Home health care supervision
G0182	Hospice care supervision
G0187	Dstry mclr drusen,photocoag
G0190	Immunization administration
G0191	Immunization admin,each add

HCPCS Code	Abbreviated Description
G0192	Immunization oral/intranasal
G0210	PET img wholebody dxlung ca
G0211	PET img wholebody init lung
G0212	PET img wholebod restag lung
G0213	PET img wholebody dx colorec
G0214	PET img wholebody init colore
G0215	PETimg wholebod restag colre
G0216	PET img wholebod dx melanoma
G0217	PET img wholbod init melano
G0218	PET img wholebod restag mela
G0219	PET img wholbod melano non-co
G0220	PET img wholebod dx lymphoma
G0221	PET imag wholbod init lympho
G0222	PET imag wholbod resta lymph
G0223	PET imag wholbod reg dx head
G0224	PET imag wholbod reg ini hea
G0225	PET whol restag headneck only
G0226	PET img wholbod dx esophagl
G0227	PET img wholbod ini esophage
G0228	PET img wholbod restg esopha
G0229	PET img metabolic brain pres
G0230	PET myocard viability post s
G9002	MCCD,maintenance rate
G9003	MCCD, risk adj hi, initial
G9004	MCCD, risk adj lo, initial
G9016	Demo-smoking cessation coun
H0016	Alcohol and/or drug services
H0021	Alcohol and/or drug training
H0022	Alcohol and/or drug interven
H0023	Alcohol and/or drug outreach
H0024	Alcohol and/or drug preventi
H0025	Alcohol and/or drug preventi
H0026	Alcohol and/or drug preventi
H0027	Alcohol and/or drug preventi
H0028	Alcohol and/or drug preventi
H0029	Alcohol and/or drug preventi
H0030	Alcohol and/or drug hotline
J0760	Colchicine injection
J0970	Estradiol valerate injection
J1000	Depo-estradiol cypionate inj
J1050	Medroxyprogesterone inj
J1055	Medrxyprogester acetate inj
J1330	Ergonovine maleate injection
J1380	Estradiol valerate 10 MG inj
J1390	Estradiol valerate 20 MG inj
J1410	Inj estrogen conjugate 25 MG
J1435	Injection estrone per 1 MG

HCPCS Code	Abbreviated Description
J1565	RSV-ivig
J1739	Hydroxyprogesterone cap 125
J1741	Hydroxyprogesterone cap 250
J2210	Methylergonovin maleate inj
J2271	Morphine so4 injection 100mg
J2500	Paricalcitol
J2590	Oxytocin injection
J2675	Inj progesterone per 50 MG
J3530	Nasal vaccine inhalation
J3570	Laetrile amygdalin vit B17
J7300	Intraut copper contraceptive
J7315	Sodium hyaluronate injection
J7320	Hylan G-F 20 injection
J7635	Atropine inhal sol con
J7636	Atropine inhal sol unit dose
J7637	Dexamethasone inhal sol con
J7638	Dexamethasone inhal sol u d
J7642	Glycopyrrolate inhal sol con
J7643	Glycopyrrolate inhal sol u d
J7658	Isoproterenolhcl inh sol con
J7659	Isoproterenol hcl inh sol ud
J7680	Terbutaline so4 inh sol con
J9165	Diethylstilbestrol injection
J9219	Leuprolide acetate implant
M0075	Cellular therapy
M0076	Prolotherapy
M0100	Intragastric hypothermia
M0300	IV chelationtherapy
M0301	Fabric wrapping of aneurysm
M0302	Assessment of cardiac output
P2031	Hair analysis
P7001	Culture bacterial urine
P9604	One-way allow prorated trip
Q0035	Cardiokymography
Q0081	Infusion ther other than che
Q0086	Physical therapy evaluation
Q0186	Paramedic intercept, rural
Q2001	Oral cabergoline 0.5 mg
Q2002	Elliotts b solution per ml
Q2005	Corticorelin ovine triflutat
Q2007	Ethanolamine oleate 100 mg
Q2010	Glatiramer acetate, per dose
Q2012	Pegademase bovine, 25 iu
Q2014	Sermorelin acetate, 0.5 mg
Q2015	Somatrem, 5 mg
Q2016	Somatropin, 1 mg
Q2018	Urofollitropin, 75 iu

HCPCS Code	Abbreviated Description
Q3013	Injection, verteporfin, 15 mg
Q4007	Cast sup long arm ped, pl
Q4008	Cast sup, long arm ped, fib
Q4011	Cast sup sh arm ped, pl
Q4012	Cast sup sh arm ped, fib
Q4015	Cast sup gauntlet ped,
Q4016	Cast sup gauntlet ped, fib
Q4019	Cast sup l arm splint ped, pl
Q4020	Cast sup l arm splint ped, fib
Q4023	Cast sup sh arm splint ped, pl
Q4024	Cast sup sh arm splint ped, fib
Q4027	Cast sup hip spica, pl
Q4028	Cast sup, hip spica, fib
Q4031	Cast sup, long leg ped, pl
Q4032	Cast sup, long leg ped, fib
Q4035	Cast sup, leg cylinder ped, pl
Q4036	Cast sup, leg cylinder ped, fib
Q4039	Cast sup, sh leg ped, pl
Q4040	Cast sup, sh leg ped, fib
Q4043	Cast sup, l leg splintped, pl
Q4044	Cast sup, l leg splint ped, fib
Q4047	Cast sup, sh leg splint ped, pl
Q4048	Cast sup, sh leg splint ped, fib
S0009	Injection, butorphanol tartr
S0012	Butorphanol tartrate, nasal
S0014	Tacrine hydrochloride, 10 mg
S0016	Injection, amikacin sulfate
S0017	Injection, aminocaproic acid
S0020	Injection, bupivicaine hydro
S0021	Injection, ceftoperazone sod
S0023	Injection, cimetidine hydroc
S0024	Injection, ciprofloxacin
S0028	Injection, famotidine, 20 mg
S0029	Injection, fluconazole
S0030	Injection, metronidazole
S0032	Injection, nafcillin sodium
S0034	Injection, ofloxacin, 400 mg
S0039	Injection, sulfamethoxazole
S0040	Injection, ticarcillin disod
S0071	Injection, acyclovir sodium
S0072	Injection, amikacin sulfate
S0073	Injection, aztreonam, 500 mg
S0074	Injection, cefotetan disodiu
S0077	Injection, clindamycin phosp
S0078	Injection, fosphenytoin sodi
S0080	Injection, pentamidine iseth
S0081	Injection, piperacillin sodi

HCPCS Code	Abbreviated Description
S0085	injection, gatifloxacin
S0086	Injection, verteporfin, 15mg
S0090	Sildenafil citrate, 25 mg
S0096	Injection, itraconazole, 200
S0156	Exemestane, 25 mg
S0157	Becaplermin gel 1%, 0.5 gm
S0199	RU486 Professional Fee
S0220	Medical conference by physic
S0221	Medical conference, 60 min
S0601	Screening proctoscopy
S0605	Digital rectal examination,
S0610	Annual gynecological examina
S0612	Annual gynecological examina
S0620	Routine ophthalmological exa
S0621	Routine ophthalmological exa
S0630	Removal of sutures
S0800	Laser in situ keratomileusis
S0810	Photorefractive keratectomy
S0820	Computerized corneal topogra
S0830	Ultrasound pachymetry
S1015	IV tubing extension set
S1016	Non-pvc intravenous administ
S2052	Transplantation of small int
S2053	Transplantation of small int
S2054	Transplantation of multivisc
S2055	Harvesting of donor multivis
S2060	Lobar lung transplantation
S2061	Donor lobectomy (lung)
S2102	Islet cell tissue transplant
S2103	Adrenal tissue transplant
S2120	Low density lipoprotein(LDL)
S2140	Cord blood harvesting
S2142	Cord blood-derived stem-cell
S2180	Donor leukocyte infusion
S2202	Echosclerotherapy
S2205	Minimally invasive direct co
S2206	Minimally invasive direct co
S2207	Minimally invasive direct co
S2208	Minimally invasive direct co
S2209	Minimally invasive direct co
S2210	Cryosurgical ablation (in si
S2220	Thrombectomy, coronary
S2300	Arthroscopy, shoulder, surgi
S2340	Chemodenervation of abductor
S2350	Diskectomy, anterior, with d
S2351	Diskectomy, anterior, with d
S2370	Intradiscal electrothermal

HCPCS Code	Abbreviated Description
S2371	Each additional interspace
S3620	Newborn metabolic screening
S3645	HIV-1 antibody testing of or
S3650	Saliva test, hormone level;
S3652	Saliva test, hormone level;
S3700	Bladder tumor-associated
S3708	Gastrointestinal fat absorpt
S3902	Ballistocardiogram
S3904	Masters two step
S3906	Transfusion, direct, blood
S5000	Prescription drug, generic
S5001	Prescription drug,brand name
S5002	Fat emulsion 10% in 250 ml
S5003	Fat emulsion 20% in 250 ml
S5010	5% dextrose and 45% saline
S5011	5% dextrose in lactated ring
S5012	5% dextrose with potassium
S5013	5% dextrose/45%saline,1000ml
S5014	5% dextrose/45%saline,1500ml
S5016	Antibiotic admin supplies w/
S5017	Antibiotic adminsupplies w/o
S5018	Pain therapy admin supplies
S5019	Chemotherapy admin supplies
S5020	Chemotherapy admin supplies
S5021	Hydration therapy admin supp
S5022	Growth hormone therapy
S5025	Infusion pump rental,perdiem
S5503	Maintenance of implanted vas
S8001	Radiofrequency stimulation
S8035	Magnetic source imaging
S8040	Topographic brain mapping
S8049	Intraoperative radiation the
S8080	Scintimammography
S8085	Fluorine-18 fluorodeoxygluco
S8092	Electron beam computed tomog
S8095	Wig (for medically-induced h
S8096	Portable peak flow meter
S8105	Oximeter for measuring blood
S8110	Peak expiratory flow rate (p
S8200	Chest compression vest
S8205	Chest compression system gen
S8210	Mucus trap
S8260	Oral orthotic for treatment
S8400	Incontinence pants, each
S8402	Diapers, each
S8405	Incontinence liners, each
S8950	Complex lymphedema therapy,

HCPCS Code	Abbreviated Description
S8999	Resuscitation bag
S9001	Home uterine monitor with or
S9007	Ultrafiltration monitor
S9015	Automated EEG monitoring
S9022	Digital subtraction angiogra
S9023	Xenon regional cerebral bloo
S9024	Paranasal sinus ultrasound
S9025	Omnicardiogram/cardiointegra
S9035	Medical equipment or supplie
S9055	Procuren or other growth fac
S9056	Coma stimulation per diem
S9061	Medical supplies and equipme
S9075	Smoking cessation treatment
S9085	Meniscal allograft transplan
S9088	Services provided in urgent
S9090	Vertebral axial decompressio
S9122	Home health aide or certifie
S9123	Nursing care, in the home; b
S9125	Respite care, in the home, p
S9127	Social work visit, in the ho
S9128	Speech therapy, in the home,
S9129	Occupational therapy, in the
S9140	Diabetic Management Program,
S9141	Diabetic Management Program,
S9200	Nursing services and all nec
S9210	Nursing services and all nec
S9220	Nursing services and all nec
S9225	Nursing services and all nec
S9230	Nursing services and all nec
S9300	Nursing services and all nec
S9308	Nursing services and all nec
S9310	Nursing services and all nec
S9395	Nursing services and all nec
S9420	Nursing services and all nec
S9423	Nursing services, patient as
S9425	Nursing services and all nec
S9435	Medical foods for inborn err
S9455	Diabetic Management Program,
S9460	Diabetic Management Program,
S9465	Diabetic Management Program,
S9470	Nutritional counseling, diet
S9472	Cardiac rehabilitation progr
S9473	Pulmonary rehabilitation pro
S9474	Enterostomal therapy by a re
S9475	Ambulatory setting substance
S9480	Intensive outpatient psychia
S9485	Crisis intervention mental h

HCPCS Code	Abbreviated Description
S9524	Nursing services related to
S9526	Skilled nursing visits for
S9527	Insertion of a peripherally
S9528	Insertion of midline central
S9533	Pain management, intravenous
S9535	Administration of hematopoie
S9539	Administration of antibiotic
S9543	Administration of medication
S9545	Administration of immune glo
S9550	Home IV therapy, hydration
S9555	Additional home infusion
S9990	Services provided as part of
S9991	Services provided as part of
S9992	Transportation costs to and
S9994	Lodging costs (e.g. hotel ch
S9996	Meals for clinical trial par
S9999	Sales tax
T1000	Priv duty/inde nurse, to 15 mi
T1001	Nursing assessement/eval
T1002	RN services, up to 15 min
T1003	LPN/LVN serv, up to 15 min
T1004	Nurs aide serv, up to 15 min
T1005	Respite care, up to 15 min
T1006	Family/couple counseling
T1007	Treatment plan development
T1008	Day treatment for individual
T1009	Child sitting services
T1010	Meals when receive services
T1011	Alcohol/substance abuse noc

HCPCS Code	Abbreviated Description
T1012	Alcohol/subs abs, skills dev
T1013	Sign lang or oral intrpr serv
V5008	Hearing screening
V5010	Assessment for hearing aid
V5011	Hearing aid fitting/checking
V5014	Hearing aid repair/modifying
V5020	Conformity evaluation
V5030	Body-worn hearing aid air
V5040	Body-worn hearing aid bone
V5050	Body-worn hearing aid in ear
V5060	Behind ear hearing aid
V5070	Glasses air conduction
V5080	Glasses bone conduction
V5090	Hearing aid dispensing fee
V5100	Body-worn bilat hearing aid
V5110	Hearing aid dispensing fee
V5120	Body-worn binaur hearing aid
V5130	In ear binaural hearing aid
V5140	Behind ear binaur hearing ai
V5150	Glasses binaural hearing aid
V5160	Dispensing fee binaural
V5170	Within ear cros hearing aid
V5180	Behind ear cros hearing aid
V5190	Glasses cros hearing aid
V5200	Cros hearing aid dispens fee
V5210	In ear bicros hearing aid
V5220	Behind ear bicros hearing ai
V5230	Glasses bicros hearing aid
V5240	Dispensing fee bicros
V5299	Hearing service

NON-COVERED MODIFIERS

All five digit modifiers listed in the CPT books (e.g. 09951)

-AJ Clinical Social Worker

APPENDIX F
DOCUMENTATION REQUIREMENTS

In addition to the documentation requirements published by the American Medical Association in CPT, the department or Self-Insurer has additional reporting and documentation requirements. These requirements are described below. No additional amount is payable for these as they are required to support billing.

Service	Code(s)	Requirements
Case Management and Telephone Calls	CPT 99361-99373	Documentation in the medical record should include: • the date, • the participants and their titles, • the length of the call or visit, • the nature of the call or visit, and • any medical decisions made during the call.
Chiropractic Care Visit	Local 2050A & 2051A	Office/chart notes
	Local 2052A	Report substantiating need for level and type of service
Consultation	CPT 99241-99275	Narrative report
Critical Care	CPT 99291 & 99292	Narrative report
Emergency Room	CPT 99281 & 99282	Report of accident and notes in the hospital medical record or report
	CPT 99283-99285	Report of accident and report
Hospital	CPT 99221-99223	Report of accident and report
	CPT 99231-99238	Narrative report
Nursing Facility	CPT 99301-99303	Narrative report
	CPT 99311	Office notes (or chart notes)
	CPT 99312 & 99313	Narrative report
Office Visit	CPT 99201 & 99202	Report of accident and office notes (or chart notes)
	CPT 99203-99205	Report of accident and report
	CPT 99211 & 99212	Office notes (or chart notes)
	CPT 99213-99215	Narrative report
Prolonged Services	CPT 99354-99359	Narrative report
Psychiatric Services	CPT 90804-90853	Narrative report
Standby	CPT 99360	Narrative report
Miscellaneous	CPT 99288 & 99499	Narrative report

APPENDIX G
REPORTS AND FORMS

These local codes and policies apply to both State Fund and Self-Insured payers. Both are referred to as the "insurer" in the table below. See **Appendix F** in the "Washington RBRVS Payment Policies" section for documentation requirements.

Report/form	Billing code	Maximum fee	Paid only when:	Limits	Special notes
Attending Physician Final Report	1026M	$31.93	Requested by the insurer	1 per day	Form will be sent from insurer. Not paid in addition to office call on same day. Must retain copy of completed form. **Payable only to the attending doctor**
Loss of Earning Power (LEP) form	1027M	$8.99	Requested by the insurer	1 per day	**Payable only to attending doctor.**
Review of Job Analysis by attending doctor performed at request of insurer or State Fund employer, **each additional review**	1028M	$15.96	Requested by the insurer or State Fund employer or VRC	5 per day	Must have a documented request from the insurer or State Fund employer or VRC. Bill to the department--see Provider Bulletin 96-10. **Payable only to the attending doctor.**
Employer Requested PCE/Physical Restrictions	1037M	$20.38	Requested by the State Fund employer	N/A	Must have a documented request from the employer. Bill to the department - see Provider Bulletin 96-10. **Payable only to the attending doctor.**
Review of Job Analysis by attending provider performed at request of insurer or State Fund employer, **first**	1038M	$31.93	Requested by the insurer or State Fund employer or VRC	1 per day	Must have a documented request from the insurer or State Fund employer or VRC. Bill to the department--see Provider Bulletin 96-10. **Payable only to the attending doctor**.
Time Loss Notification Form	1039M	$8.99	Requested by the insurer	1 per day	Payable only to attending doctor.
Report of Industrial Injury or Occupational Disease form	1040M	$24.45	Initiated by the injured worker or attending doctor	1 per claim	Only MD's, DO's, DC's, ND's, DPM's, DDS's, and OD's may sign and be paid for completion of this form.
Reopening Application form	1041M	$24.45	Initiated by the injured worker or insurer	1 per request	Only MD's, DO's, DC's, ND's, DPM's, DDS's, and OD's may sign and be paid for completion of this form.
Doctors Estimate of Physical Capacities form	1048M	$20.38	Requested by the insurer or vocational counselor	1 per day	**Payable only to attending doctor.**

Report/form	Billing code	Maximum fee	Paid only when:	Limits	Special notes
Copies of Records	1051M	$0. 41/page	Requested by the insurer		**Not payable for records required to support billing per WAC 296-20-125.** Only paid for copies of previous records specifically requested by insurer. Not payable for records requested by worker, worker's attorney or other parties including providers.
Occupational History Form (Review of claimant information and preparation of report on relationship of occupational history to present condition(s).)	1055M	$154.01	Requested by the insurer	N/A	**Payable only to the attending doctor** when completing an occupational disease report of accident or upon request from the insurer.
Supplemental Medical Report (SMR)	1056M	$15.10	Requested by the insurer	1 per day	**Payable only to attending doctor.**
Attending Doctor Review of IME Report	1063M	$32.60	Requested by the insurer	1 per request	**Payable only to attending doctor.**
Opioid Progress Report supplement	1057M	$15.10	The worker is prescribed opioids for chronic, noncancer pain.	1 per day	When opioids are used to treat chronic, noncancer pain. This form must be submitted at least every 60 days. **See WAC 296-20-03021 and Provider Bulletin 00-04.**
Initital report documenting need for opioid treatment	1064M	$31.93	Initiating opioid treatment for chronic, noncancer pain	N/A	**See WAC 296-20-03020 for the required details of the narrative report and also Provider Bulletin 00-04.**
Sixty Day Narrative/Special Reports	99080	$31.93	Requested by the insurer	1 per day	**Sixty day reports are required per WAC 296-20-06101 and do not need a department request.** Job Analysis review and Physician's Final Report have separate codes. Special reports require a specific request. This code is not payable for records required to support billing or for review of records included in other services.

APPENDIX H
RECORD KEEPING REQUIREMENTS

As a provider with a signed agreement with the department, you are the legal custodian of the injured workers' medical records. You must include subjective and objective findings, records of clinical assessment (diagnoses), as well as reports and interpretations of x-rays, laboratory studies and other key clinical information in patient charts.

Providers are required to keep all records necessary for the department to audit the provision of services for a minimum of five (5) years. (*See WAC 296-20-02005 Keeping of records.*)

Providers are required to keep all x-rays for a minimum of ten (10) years. *(See WAC 296-23-140 Custody of x-rays.)*

For progress and ongoing care use the standard "SOAP" (Subjective, Objective, Assessment, Plan and progress) format. Chart notes should also document Employment issues, including a record of the patient's physical and medical ability to work, and information regarding any rehabilitation that the worker may need to undergo. Restrictions to recovery and any temporary or permanent physical limitations need to be documented, as well as any unrelated condition(s) that may impede recovery.

"SOAP-ER" CHARTING FORMAT

S Subjective complaints.
O Objective findings.
A Assessment.
P Plan and progress.
E Employment issues.
R Restrictions to recovery.

Providers are required to maintain documentation in workers' medical files to verify the level, type and extent of services provided to injured workers. A provider's level of payment for a specific visit or service can be denied or reduced if the required documentation is not provided or indicates the level or type of service does not match the procedure code billed.

TIPS TO AVOID BILLING PROBLEMS

- Please mail your reports and chart notes separately from your bills - sending the two documents together can delay or even prevent information from reaching the claims manager.

  For State Fund claims: Send reports to: **Department of Labor and Industries**
  PO Box 44291
  Olympia, Washington 98504-4291.

  For Self-Insured claims: Send reports to the employer or their service company.

- Put your patient's name and claim number in the upper right hand corner of all pages of your reports and chart notes.

- If you submit more than one report at a time about a claimant, staple together all reports pertaining to the claim number.
- Make your chart notes and reports legible.
- Create and send office notes to the department or Self-Insurer for all follow-up visits.
- Chart notes must substantiate the level and type of service performed.
- Chart notes are not acceptable in lieu of the 60-day report.
- If you use abbreviations, please provide a copy of your abbreviation key with all chart notes submitted.
- Separate payment for submitting documentation of services performed or photocopying documentation is not allowed.

The following information must be contained in narrative or consultation reports submitted to the department or Self-Insurer:

- History
- Physical examination
- Condition(s) diagnosed including ICD-9-CM codes and the objective and subjective findings
- Outline of proposed treatment program: its length, components, expected prognosis including when treatment should be concluded and the condition(s) is/are stable.
- Expected degree of recovery from the industrial condition
- Probability of returning to work and an estimated return to work date
- Probability, if any, of permanent partial disability resulting from industrial conditions
- A doctor's estimate of physical capacities should be included if the worker has not returned to work
- Reports of necessary, reasonable x-ray and laboratory studies to establish or confirm the diagnosis when indicated

For more information on documentation and record keeping requirements, please refer to:

- WAC 296-20-01002 Definitions
- WAC 296-20-02005 Keeping of records
- WAC 296-20-06101 Reopening requirements